

791

JANUARY 1979

MARYLAND STATE MEDICAL



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...Page 35



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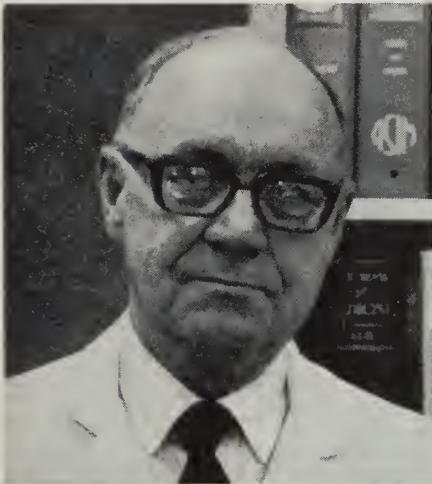
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*PATIENT CARE Magazine—Outlook 1977, "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



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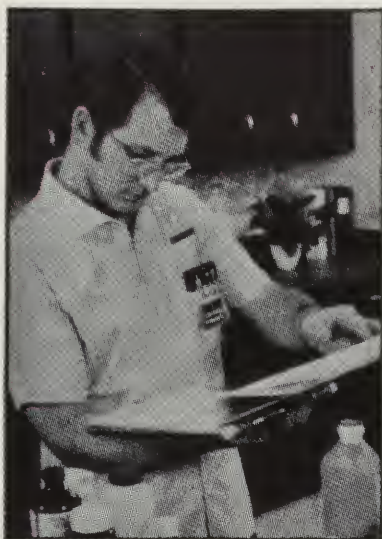


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Volume 28

JANUARY, 1979

Number 1

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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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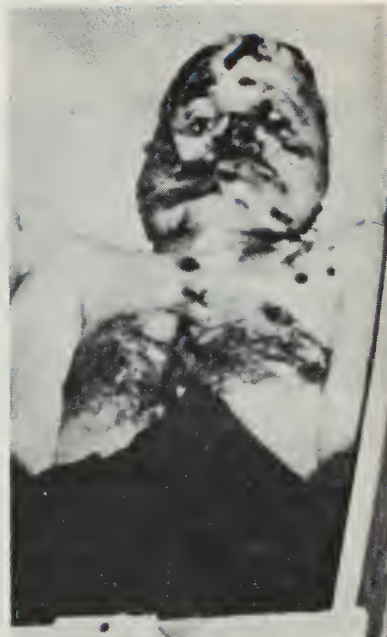
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THE BATTERED, BULLET-RIDDLED CORPSE OF BENITO MUSSOLINI In Milan, April, 1945. Some aspects of his medical case history are discussed, beginning on p. 35 in this issue. (UPI pix.)

The Cover: Kaiser Wilhelm II in the Death's Head Shako and uniform of the Zieten Hussars.

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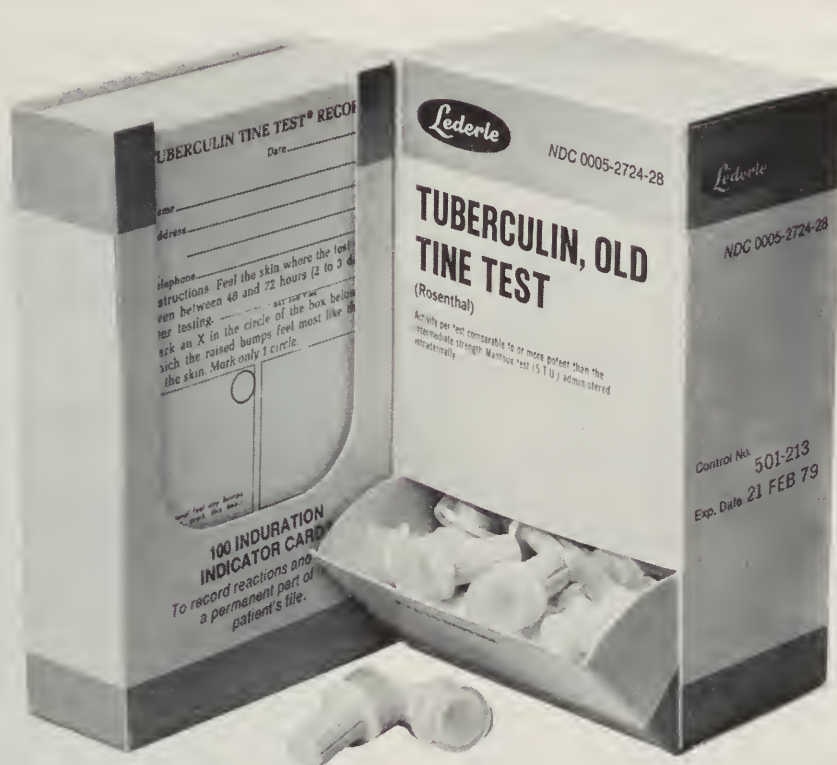
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Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.



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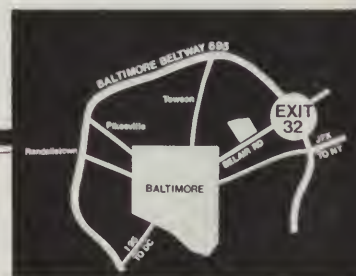
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Renal Tubular Acidosis

By LEE A. GOODMAN, MD

Dr. Goodman is Assistant Professor at the University of Maryland Hospital, 22 S. Greene St., Balto., MD 21201.

Case History

This 16-year-old female has been followed for several years for a metabolic problem. She first presented with evidence of poor physical growth as well as easy fatigability. She has also experienced bouts of intermittent renal colic. Laboratory evaluation revealed a metabolic acidosis. An abdominal film was obtained (Figure 1). Following that, an intravenous pyelogram was performed. Figure 2 is the nephrographic tomogram obtained early in the IVP, and Figure 3 is a later excretory film.

1. What is your prime diagnosis? Differential diagnosis?

2. What metabolic abnormalities might be expected?

Answer on next page.



FIGURE 1

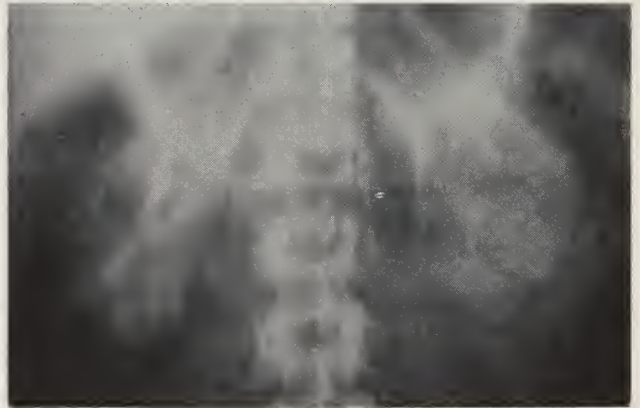


FIGURE 2



FIGURE 3

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Radiological Case of the Month.

Case history on preceding page.

Discussion

The plain film of the abdomen reveals multiple small, punctate calcifications overlying the kidneys. The renal location of these calcifications is confirmed on the IVP. A further note is the fact that the calcifications are clumped within the medullary portion of the kidneys and, more specifically, in the distribution of the renal papillae—they are not within the collecting systems. If they were within the collecting system (calyces), then the contrast material on the IVP would be expected to obscure the calculi.

Calcification within the kidneys can be classified according to the location of the calcific deposits. Calculi within the collecting systems, referred to as nephrolithiasis, is by far the most common; 85% of calculi within the calyces or ureters are radiodense; that is, they are visible on plain films. Calcification in the kidney can also be situated in the renal parenchyma. This second category is referred to as nephrocalcinosis and can then be subdivided into cortical calcifications and medullary calcifications. Cortical nephrocalcinosis, by far the rarest, can be caused by chronic glomerulonephritis, acute cortical necrosis and several other very unusual entities. Medullary nephrocalcinosis, on the other hand, is not as rare. The present case exhibits this medullary or papillary form.

The differential diagnosis of medullary nephrocalcinosis includes renal tubular acidosis, medullary sponge kidney, hyperoxaluria and multiple entities causing hypercalcemia as well as hypercalcuria. These include primary hyperparathyroidism, metastatic carcinoma to the bone, sarcoidosis, milk-alkali syndrome and hypervitaminosis D. As noted, these calcifications occur in the renal papilla in the area of the distal tubule. It is at this site that the greatest concentrations of ions are achieved. Very often, the many causes of medullary nephrocalcinosis are difficult to differentiate radiographically.

In this case, the patient had a long history of a metabolic acidosis and carried a diagnosis of renal tubular acidosis (RTA). This disease has been defined, in its simplest terms, as an inability of the kidney to make urine with a pH of less than 5.4. More specifically, the distal nephron is unable to secrete hydrogen ion (H^+) against a gradient. As the patient becomes more acidotic, there is a fall in the blood pH and plasma bicarbonate level as well as an increase in plasma chloride. The resultant alkaline urine favors calcium precipitation and stone formation in the renal papillae and in the calyces. The specific tubular defect in RTA has been subdivided into "proximal" (not associated with nephrocalcinosis) and "distal" (commonly associated with nephrocalcinosis). The distal form can be further categorized into "complete," as in this case, or "incomplete," where the electrolytes are normal.

Clinically, the syndrome is often idiopathic and can be either transient or persistent. It can affect patients ranging in age from infants to the very elderly. It has also been described in association with many other

disorders (secondary RTA) such as Fanconi syndrome and several of the hyperglobulinemic states including multiple myeloma. The full-blown clinical picture of renal tubular acidosis includes symptoms secondary to urolithiasis, muscle weakness or paralysis, cardiac arrhythmias, osteomalacia, growth retardation, polyuria and even overt renal failure. Treatment is basically geared to correcting the metabolic abnormalities.

Radiographically, the most common presentation is a diffuse medullary form of nephrocalcinosis. The IVP will not, however, reveal any evidence of cystic dilatation of the distal tubules as might be seen with medullary sponge kidney. This is occasionally helpful in distinguishing these two entities. Patients with RTA can also develop prominent stones within the calyces and ureters. The radiographic signs of osteomalacia including generalized osteopenia, skeletal deformities and pseudofractures are occasionally seen.

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- 1) Courey, W. Robert and Pfister, Richard C.: The Radiographic Findings in Renal Tubular Acidosis, *Radiology*, 105:497, December, 1972.
- 2) Davidson, Alan J.: Radiologic Diagnosis of Renal Parenchymal Disease, W. B. Saunders Company, 1977.
- 3) Witten, David M., Myers, George H., Jr. and Utz, David C.: Clinical Urography, W. B. Saunders Company, 1977. ☐

Miscellaneous Meetings

Jan. 8-12, 1979 Seminars in Diag. Rad. Contact Assoc. Dir. of Educ. Armed Forces Inst. of Pathology (EDZ), Wash., DC 20306.

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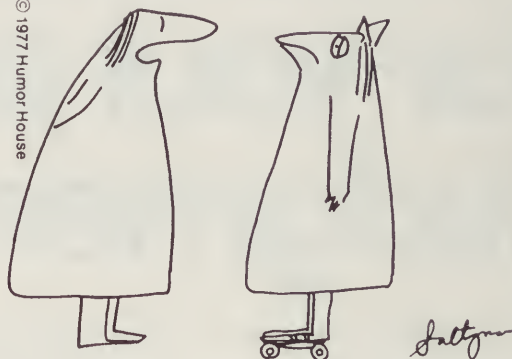
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MARK BOWDEN

Reporter, The Baltimore News American
P.O. Box 1795,
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(Managing Editor's Note: Mr. Bowden's note was in reference to the *Journal's* October, 1978 interviews with Gubernatorial candidate J. Glenn Beall and now Governor Harry R. Hughes, both of whom he'd interviewed earlier, during the Primary Election Campaign, for the Maryland Hospital Association. Quotes from the same exclusive *Journal* interviews were spotlighted in the column of *News American* writer Louis Azrael on Oct. 26, 1978.—BT.)

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To the Editor:

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THE STRANGE CASE OF WHITE HOUSE AIDE DR. PETER BOURNE was examined in the **Journal's** November, 1978 Health in History offering.

(White House picture.)

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Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

Journal announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.



HARRY HUGHES BEING INTERVIEWED BY THE JOURNAL, Sept. 18, 1978. (Photography by Claude Brooks, Owings Mills, MD.)

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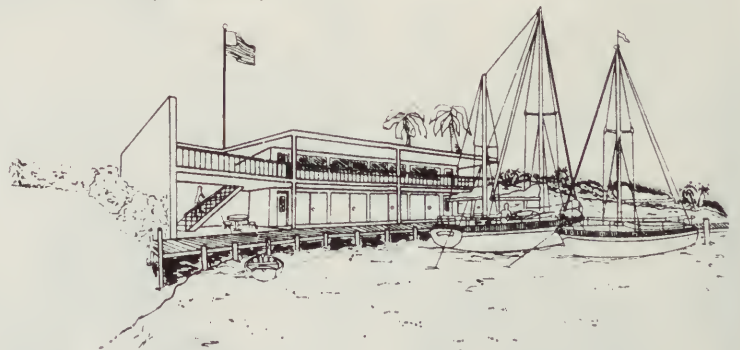
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Executive Director's Newsletter

January, 1979

PRESCRIPTION

BLANKS

The Faculty office has been alerted by the Division of Drug Control that some physicians are leaving both signed and unsigned Medical Assistance Prescription forms in pharmacies. In some instances, it has been found that the drug issued is not the drug ordered by the physician. Physicians are advised, once more, that this practice is illegal and violators are very likely to be prosecuted. The Committee on Drugs strongly emphasizes that the practice of leaving prescriptions in pharmacies (whether Medicaid or not) is not only bad medical practice, but illegal and cannot be condoned.

LEGISLATIVE

HOTLINE

The 1979 session of the Maryland General Assembly convenes on Wednesday, January 10, 1979. The 90-day session ends at midnight, Monday, April 9, 1979. During the session, Faculty members will be kept up-to-date on legislative activities through The Assemblyman newsletter and the legislative HOTLINE. The HOTLINE number for 1979 is the same as last year:

1-800-492-9373.

1979 DUES

BILLS

1979 Dues bills are in the mail to all members. Dues must be paid by January 31, 1979, in order to be eligible for panels for physicians' defense. If your bill has not been received, please contact the Faculty Accounting Department, 539-0872.

RESOLUTIONS

DEADLINE

The bylaws of the Faculty provide that resolutions to be submitted to the House of Delegates at the Faculty's Annual Meeting must be in the Faculty office eight weeks before the date of the Annual Meeting.

The dates for the Annual Meeting are May 2 through 5, 1979; therefore, resolutions must be in our hands by

FRIDAY, MARCH 9, 1979.

CORRECTION

In the November Newsletter it was reported that physicians fees had increased .08% when this should have been 0.8%; and the figure quoted as .06% should have read 0.6%.

The period covered was for the 12 months ending August, 1978. Other data in this news item is correct.

SECOND
OPINIONS

Second opinion programs are now in effect for Medicare recipients, as well as selected groups, through Blue Shield of Maryland, Inc., and through some commercial carriers.

Contrary to what has been publicized, not all Blue Shield subscribers are eligible for payment for second opinions; nor are all subscribers to commercial insurers eligible.

Physicians are urged to carefully evaluate their billing procedures when rendering a second opinion on individuals requesting such consultation.

The Faculty's Council has adopted a position statement in connection with second opinions which can be found on page 76 of this issue of the Journal.

SPECIAL
AWARD

In conjunction with the National Association of Medical Exploring, the AMA will recognize an outstanding medical explorer or explorer post at the 1979 Annual Meeting of the House of Delegates. For details, contact the Faculty office, 539-0872.

MEDICAID
TO USE
CPT4

Effective for procedures carried out on February 1, 1979, and thereafter, the Medicaid program will commence to use CPT4 for processing all bills received for services rendered to recipients.

A special mailing has been sent to all physicians who treat Medicaid patients. In this communication, full details are spelled out as to how billing should be done. Certain adjustments in some surgical fees are being implemented at the same time.

Copies of the CPT4 may be obtained from the Faculty office at a price of \$12.00. The appropriate payment must be received prior to mailing of the book.


Executive Director

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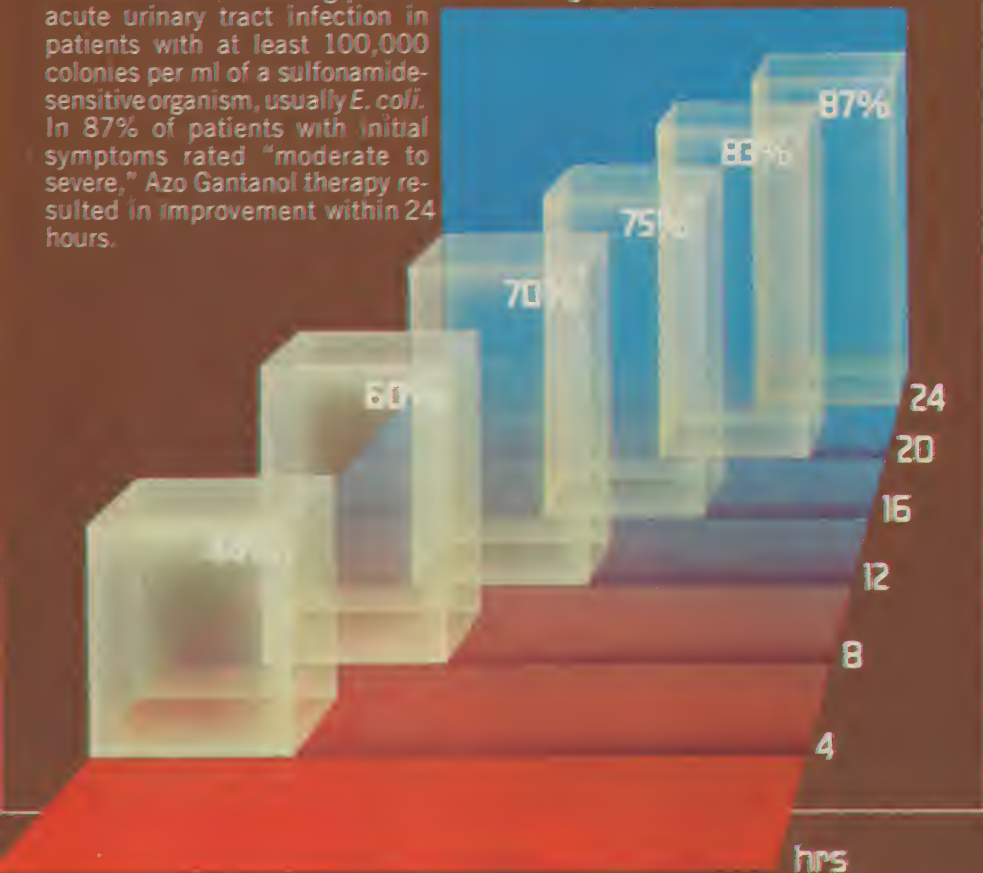
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for the pain for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note:** Fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; aminobenzoic acid to follow-up culture media, increasing frequency of resistant organisms limit the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels; variations may occur, 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12, sulfonamide hypersensitivity; pregnancy at term or during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (fever, throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC (urinalysis with microscopic examination are recommended during sulfonamide therapy).

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe chronic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria or stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruption, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I.* reactions (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS* reactions (headache, vertigo, neuritis, mental depression, convulsions, and hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, nephrosis with oliguria and anuria, perianteritis, nodules and *E. coli* phenomenon). Due to certain chemical similarities with some goitrogens, uratics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused instances of goiter production, diuretic and hypoglycemia. Cross-sensitivity with these agents is rare.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. Usual adult dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists other than infection should be sought. After relief of pain has been obtained, continue treatment with Gantanol (sulfamethoxazole) if considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine. **Supplied:** Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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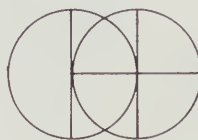
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Medical Miscellany

A Strategy For Physician Involvement in Health Planning

The National Health Planning and Resource Development Act of 1974 (PL 93-641) has been receiving increasing attention in the physician community. This is most appropriate, as this law prescribes specific national health goals and priorities, and provides for local and State planning agencies with expanded powers.

Since the consumer/provider ratio required for the Health Systems' Agency governing body means that physician participation in the planning process will be limited, it is essential that physicians organize to make their input as effective as possible.

There are two physician organizations with good reasons to be interested in the HSA's activities. These are local and state medical societies and Professional Standards Review Organizations. Medical societies have been the traditional lobby for physician interests, and they should expect to continue that role vis-à-vis Health Systems' Agencies. The individual physician's practice can be affected by the HSA's decisions—for example, the decision to grant or refuse a hospital's application for a certificate of need for expansion will affect the number of beds available for the physician's use.

Also, the HSA's analysis of the health care system will certainly include discussion of the adequacy of medical care in the area, and the HSA's analysis of the system will lead to plans for changing it.

PSROs are a relatively new physician organization, but their interest in the Health Systems' Agency should be just as strong as that of medical societies. The Federal regulations concerning HSAs designation require HSAs to establish working relationships with PSROs for the exchange of data, as well as for other purposes. This gives PSROs a means of influencing HSA activities and plans, and therefore guarantees that physicians will have a voice in the planning process.

How effective that voice is will depend on how well organized the physician community is. Physicians can be most effective if they pool the resources of the medical society and the PSRO, plan a strategy and timetable for involvement ahead of time and then stick to it. This type of organized effort really calls for the establishment of a joint medical society/PSRO committee.

A joint committee, with the Chairperson and members appointed by the Presidents of the Society and the PSRO, ensures that the interests of both organizations are represented in discussion with the HSA. It also ensures that the physicians who hold these discussions with the HSA speak for the medical community and not just for themselves.

In order to develop a strategy for involvement and to keep up with HSA issues, this committee should

meet regularly, probably on a monthly basis. The kinds of activities this committee will carry out will vary from one HSA area to another. Its activities could include supporting the nomination of physicians to the HSA governing body and informally developing contacts with non-physician governing body members.

This increases the visibility of physicians to the governing body as a whole, and can lead to service on HSA committees. The committee will certainly want to study the health plans the HSA develops and comment on them at public hearings. These possible activities suggest that a mixture of informal and official activity by the committee is desirable.

It is clear that the members of this committee will have to be very well informed on health planning issues. The volume of information that will have to be read and absorbed may be greater than many physicians have the time or willingness to spare. However, both medical societies and PSROs have individuals on their staffs who can read these reports in their entirety, summarize them, and prepare recommendations for the committee. This can cut the demand on the committee members' time by half. After the committee has reviewed the staff report and reached a consensus regarding it, the staff can be directed to develop the committee's response into draft testimony, for further review by the committee. This further cuts the time demand on the committee members. Of course, staff can take over routine information gathering and communications for the committee as well.

Where both the medical society and the PSRO have staff who have time to work with the HSA committee, it is probably best to have both organizations contribute staff time. This assures that both groups continue to feel that they have a serious investment in the committee and its work.

However, the medical society's funding may be much more limited than the PSRO's, making it impossible for the society to provide staff to the committee. In this case, it seems appropriate for the PSRO to provide all of the staff support. The PSRO and HSA are both Federally funded, and by Federal regulations they are required to work together. Therefore, use of PSRO staff to support an HSA committee is a legitimate PSRO activity.—Marvin Mones, MD, FAAP, Past President, Montgomery County Medical Society. □

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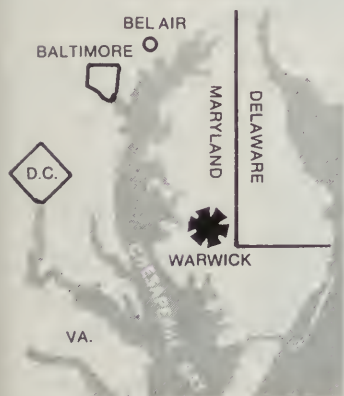


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MRS. M. McKENDREE BOYER ACCEPTS AMPAC LEADERSHIP AWARD FOR MARYLAND. Maryland was one of 26 states to receive the AMPAC Leadership Award at the opening session of the AMA House of Delegates, June 18th, in St. Louis. This award is presented to those states whose Medical Society Officers, Delegates, Alternate Delegates and PAC Chairman are all sustaining members of PAC. MMPAC has been so honored the past two years. Helen Boyer, MMPAC Vice Chairman, accepted the award on behalf of Maryland and Richard Moschell, MD, MMPAC Chairman.



AMPAC

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Medical Miscellany

Hopkins Allergy Clinic Testing Hayfever Treatment

The Johns Hopkins Hospital Allergy Clinic is seeking patients who suffer from hayfever primarily during the months of August and September to participate in a study of injection treatment.

Doctors have known since the early 1900s that injecting extracts of some substances which cause allergies, such as ragweed, could lower a sperson's sensitivity to those substances. Since then, several approaches to this therapy have been developed.

The Hopkins investigation will compare the effects of the two major methods of injection therapy in a controlled study.

Patients wishing to be included in this study will receive a screening allergy evaluation. Those patients finally selected will be placed on a controlled program of weekly therapy. Treatment will be given free of charge.

Individuals between the ages of 18 and 50 who are interested in participating in this program should call (301) 685-3311. ☐

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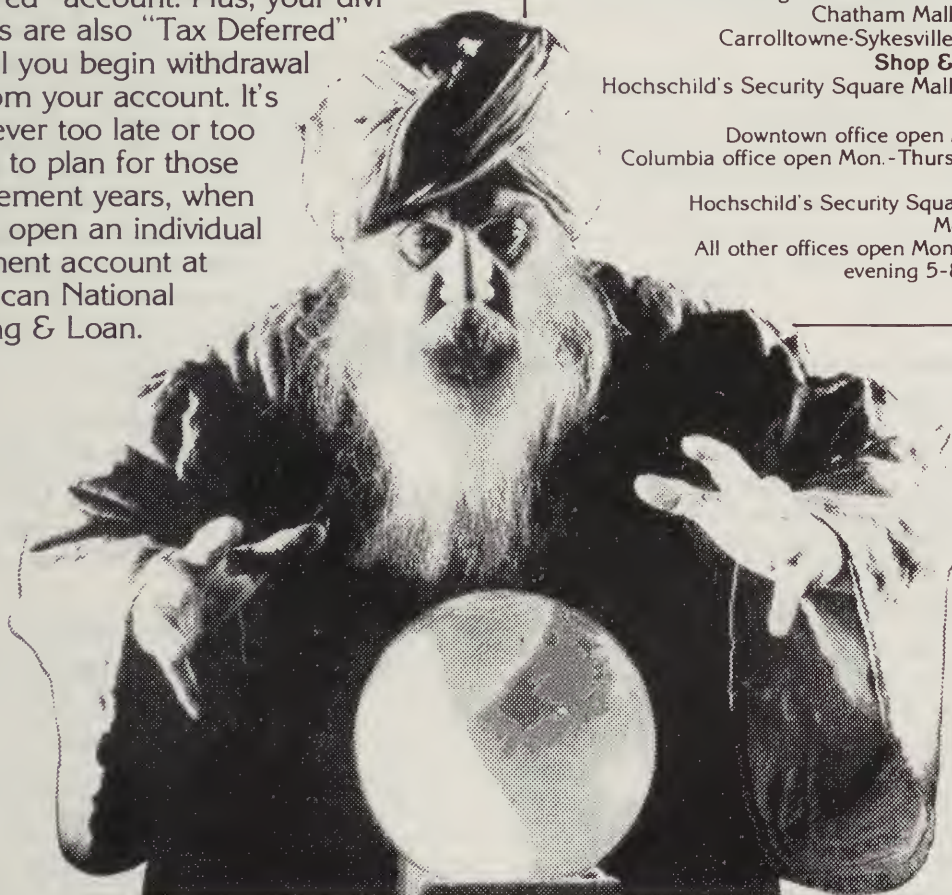
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Baltimore City Medical Society

CONRAD ACTON, MD, Editor

New Approaches

The October, 1978 Meeting of the BCMS concerned itself with **New Approaches in Peptic Ulcer and Esophagitis**. Henry Wagner, MD, Chairman of the Program Committee, introduced Turner E. Bynum, MD, Assistant Professor of Medicine at Hopkins and Director of its Endoscopy Unit and G-I Laboratory. Starting with definitions, he emphasized that all upper gastrointestinal ulcers are peptic, but are not all the same in signs, symptoms, course and complications. He finds that most physicians and patients equate esophagitis with heart burn. He reviewed briefly the biology of ulceration and the significance of stricture, reflux, pH and duodenal enzymes. Peptic ulcer of the duodenum, he noted, is having a worldwide decreased incidence, although the natural history of peptic ulcers generally is to recur.

Traditional control of ulcer symptoms with antacids is poorly satisfactory. Milk, a favorite mainstay, actually increases acid production. Magnesium-base antacids can cause diarrhea, while those of aluminum salts constipate. Control with diet and anticholinergics has compliance problems.

Newer, more physiologic therapy has been directed toward items in gastric juice besides acid. Histamine is used to stimulate acid secretion when given in small doses. In larger doses, it can effect cimetidine block and permit healing. Complications such as perforation, CNS symptoms and effect on granulocytes must be reckoned with. It is used enthusiastically in England. Experimentally-permitted trials on this side of the Atlantic have not found it as effective.

Prostaglandins have also been tried experimentally and found effective. These are Prostaglandins E_1 E_2 A_1 ; however they are not allowed for use in the United States. Dr. Bynum feels that the future for control of peptic ulcer lies with the prostaglandins. Another drug, metapropamide, increases gastric emptying and could be useful for that effect, but it, too, is not available here.

Directors Meet

The Board of Directors got a full report from John Mulholland, MD about our exhibit at the Baltimore City Fair, our first. This was a project of the Public Relations Committee and was planned well in advance and carried out with great care and attention; 16 physicians gave their time to explain the sets and answer questions. A series of pictures taken of the action was passed around. Public response was felt to be good.

Several pitfalls became apparent and to be avoided at subsequent showings, such as the **time**, in conflict

with the Med-Chi Semiannual Meeting in Ocean City. Many physicians who would have helped, could not. The location was in proximity to booths devoted to proprietary promotions and it was felt, on this account, to be a poor one. The **competition** with other health-related groups, each espousing a worthy-enough cause, diluted effectiveness. The BCMS exhibit's push was for "the health of ALL the people" and could not limit itself to any special interest. These and other factors will be kept in mind in arranging future showings.

Fred Heldrich, MD presented the Program Committee's list of topics for 1979's monthly meetings. The 10 titles were carefully scanned by the Directors and only one was vetoed, though two more were considered chancy. Clinical topics were considered the prime attendance-builders. Titles appealing to the practitioner's interest should have the highest priority. These are such as "How to" and controversial issues that influence their practice or follow-ups on controversies. Also, the Directors discussed the fact that our meetings are accredited as CME by other organizations. Our scientific programs are highly educational, and it was felt that BCMS should be in a position to self-accredit its own programs. The means to do this will be sought.

Committee Work

Richard London, MD presented a studied report from his Policy and Planning Committee. This Committee carefully noted the changes to each of BCMS's committees and evaluated each Committee's degree of attainment. Planning Committee members attended meetings of other committees, reviewed their minutes, and brought their findings to the Planning Committee. Among the Planning Committee's recommendations, the Directors approved transfer of the subjects of mental health, alcoholism and drug abuse to the Health Care Delivery Committee. The Directors also agreed to do away with the Foreign Medical Graduate Subcommittee as no longer needed. The Professional Education Committee would then limit itself to CME and merge with the Program Committee. □

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Library Expansion

Your Faculty Library is expanding! It is about two years away, but the time will come when you will find a reading room, current books and journals, and reference services all housed on the first floor of the present Faculty Building. The new arrangement will also include a History of Medicine room, a Faculty dining room with an expanded kitchen and a lounge.

All this comes about as a result of successful negotiations with the City of Baltimore for the purchase of the large building to the south of the present Faculty offices. This building (formerly School Number 49, also known as the Robert E. Lee School) is being remodeled into a headquarters building for the Faculty. When most of the Faculty's staff move next door, the Library will have much-needed room for growth. It is no secret that the Library's present stacks are almost full. Furthermore, with every addition to the Library staff, there has been a cutback in public space in the Library. For example, there has been no current periodicals room during the last year and a half.

In the new arrangement, a reading room, stacks for the current books and journals and the Public Services Department will all be located on the first floor. The present reading room will become the Louis A. M. Krause, MD History of Medicine Room, where the Faculty's rare book collection can be appropriately housed and displayed. Most important of all, shelf space for the large journal collection will be increased to allow for many years' growth.

A lounge and dining room for use by Faculty members attending committee meetings or Faculty functions will be located in the basement (near the present Journal office . . . ed. note.) We hope this area will also include display cases for the Faculty's collection of antique medical instruments.

Planning for remodeling the school building and expanding the Library is underway now. The recently-completed Library remodeling was planned to coordinate with these changes. Although the end results are still a couple of years off, they are real and can be looked forward to.

During the expansion, the Library will be seeking contributions to cover some of the costs. We hope to get fine, locking bookcases for the rare book collection, and museum cases for the instruments. We will also need new shelving for the additional stack areas and furniture for the reading room. The fact that you have a modern, efficient medical library available today results from the generosity of previous Faculty members. You can show your gratitude to these great physicians by helping to ensure that the next generation of physicians will have the same services and privileges as those you enjoy.

All contributions for the expanded Library will be appropriately and publicly acknowledged. Plaques and memorials on the present Library walls acknowledge the past contributions of Faculty members, and in the new, expanded Library, we hope to carry on this tradition. For additional information regarding contributions, please contact me at the Faculty Library.

Faculty's Art Objects to be Part of Exhibit at the Walters Art Gallery

George Lucas and the Paris Art World, 1860-1905 is the title of an exhibition scheduled to open at the Walters Art Gallery on Jan. 29, 1979. The show will run through the end of March, 1979.

A bronze plaque honoring Frank Frick, which hangs over the mantel in the Faculty Library's reading room, will be included in this exhibition. Frank Frick was a close friend of George Lucas, and this plaque represents a pertinent addition to the show.

Frank Frick was a brother of Charles Frick, MD (1823-60). In 1896, when the Faculty was desperately searching for adequate space for its reading room and Library, Frank Frick and his brother, William F. Frick, made a contribution in memory of their brother Charles to set up a reading room and Library in the then-new Faculty building at 847 N. Eutaw St. Income from the Frick endowment still helps to maintain the Faculty Library's journal collection. A large plaque in the cataloging office of the Library commemorates the Frick brothers' generosity.

JOSEPH E. JENSEN
Librarian



Toxic Substances Data Available from the Faculty's Library

Faculty members can now obtain comprehensive information about poisonous substances from one source. Toxicology Data Bank (TDB) combines the toxic chemical information from the authoritative sources (AMA Drug Evaluation, Merck Manual, Goodman and Gilman's The Pharmacological Basis of Therapeutics, etc.). This new computerized service, TDB, is part of the MEDLARS network. TDB differs from MEDLINE and other similar databases in that it provides facts regarding toxic substances instead of references to literature.

The data of TDB is extracted from many different sources: handbooks, textbooks and monographs. All the information is referenced so the original source may be consulted for more details. Each chemical record has been screened by NIH's Toxicology Study Section, composed of pharmacologists, toxicologists and analytical chemists.

Records contain chemical, toxicological and pharmacological information. Warnings, cautions, antidotes and treatments are examples of the information available for each compound. Evaluations of 1,100 compounds have been completed. An additional 1,400 compounds are in various stages of evaluation.

Searches of this database (and all MEDLARS databases) are available to the Faculty's members as a benefit of their membership. To try this new system, call or stop by the Faculty's Library.

ADAM S. SZCZEPANIAK, JR.
Assistant Librarian

New Book Titles

Available now for your use from the Med-Chi Library.

Cardiology

WG 298 **Angina Pectoris.** New York, Churchill Livingstone, 1977.
.A5882
1977

WG 168 **Ochsner, John L. Coronary Artery Surgery.** Phila. Lea and Febiger, 1978.
.O16c
1978

Chronic Diseases—Economics

W 74 **Birnbaum, Howard The Cost of Catastrophic Illness.** Lexington, MA, Health, 1978.
.B619c
1978

Color Perception

WW 150 **Ciba Foundation Ciba Foundation Symposium on Color Vision.** Boston, Little, Brown, 1965.
.C567c
1965

Diagnostic Tests

QY 25.3 **Wallach, Jacques Interpretation of Diagnostic Tests.** 3rd ed. Boston, Little, Brown, 1978.
.W191i
1978

Geriatrics

WT 100 **Adams, George Essentials of Geriatric Medicine.** New York, Oxford, Oxford Univ. Press, 1977.
.A213e
1977

WY 115 **Brickner, Phillip Home Health Care for the Aged.** New York, Appleton-Century-Crofts, 1978.
.B849h
1978

Gilles De La Tourette's Disease

WM 170 **Gilles de la Tourette Syndrome.** By Arthur K. Shapiro. New York, Raven Press, 1978.
.G477
1978

Gastroenterology

WI 380 **Fromm, David Complications of Gastric Surgery.** New York, Wiley, 1977.
.F932c
1977

WI 100.3 **Gastrointestinal Pathophysiology.** Edited by Frank P. Brooks. 2d ed. New York, Oxford Univ. Press, 1978.
.G257
1978

Gynecologic Diseases

WQ 100.3 **Adolescent Obstetrics and Gynecology.** Edited by A. Karen Kessler Kreutner and Dorothy Reycroft Hollingsworth. Chicago, Year Book Med. Pub., 1978.
.A239
1978

Histology

QS 504 **Bailey, Frederick Bailey's Textbook of Histology.** 17th ed., Bolto., Wil-

.B154t liams and Wilkins, 1978.
1978

Medicine

WB 300 **Clinical Medicine and Therapeutics.** Ed. by Peter Richards and Hugh Mather. Oxford, Blackwell Scientific Pub., 1977.
.C641
1977

W Comroe, Julius
20.5 **Retrospectroscope.** Menlo Park, CA. Von Gehr Press, 1977.
.C738
1977

Mental Disorders

WS Stewart, Mark
350 **Psychological Disorders of Children.** Balto., Williams and Wilkins, 1978.
.S851p
1978

Microscopes

History
QH 211 **Billings, John The Billings Microscope Collection of the Medical Museum, Armed Forces Institute of Pathology.** 2d ed. Wash., Armed Forces Institute of Pathology, 1974.
.B598b
1974

Neoplasms

QZ 200.3 **Altman, Arnold Malignant Diseases of Infancy and Childhood.** Phila., Saunders, 1978.
.A468m
1978

Organic Chemistry

QU 4 **Bio-organic Chemistry.** San Francisco, London, Freeman, 1968.
.B616
1968

Regional Enteritis

WI 420 **Crohn's Disease: Aetiology, Clinical Manifestations and Management.** London, Macmillan, 1977.
.C9411
1977

Respiratory Tract Diseases

WF 140 **Current Respiratory Care.** Ed. by Kenneth F. MacDonnell and Maurice S. Segal. Boston, Little, Brown, 1977.
.C976
1977

World Health

WA 540.1 **Basch, Paul International Health.** New York, Oxford Univ. Press, 1978.
.B298i
1978

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Walking and Hiking: Articles Available Through the Med-Chi Library

"Physiological Adjustments of Young Men to Five-Hour Desert Walks," by Dill, D.B. et al. **J. Appl. Physiol.** 40(2):236-42, February, 1976.

"Habitual Toe-Walkers. A Clinical and Electromyographic Gait Analysis," by Griffin, P.P. et al. **J. Bone Joint Surg. (Am)** 59(1):97-101, January, 1977.

"Variability in Synergy Patterns of Leg Muscles During Climbing, Descending and Level Walking of Highly-Trained Athletes and Normal Males," by Townsend, M.A. et al. **Electromyogr. Clin. Neurophysiol.** 18(1):69-80, January-March, 1978.

"Mechanical Work and Efficiency in Level Walking and Running," by Cavagna, G.A. et al. **J. Physiol. (London)** 268(2):647-81, June, 1977.

"The Sources of External Work in Level Walking and Running," by Cavagna, G.A. et al. **J. Physiol. (London)** 262(3):639-57, November, 1976.

"Energy Cost of Running and Walking in Young Women," by Falls, H.B. et al. **Med. Sci. Sports** 8(1):9-13, Spring, 1976.

"Objective Documentation of Increased Walking Tolerance," by Brennan, G.P. **Phys. Ther.** 58(6):697-9, June, 1978.

"Optimal Back-Pack Load for Short Distance Hiking," by Shoenfeld, Y. et al. **Arch. Phys. Med. Rehabil.** 59(6):281-4, June, 1978.

"Maximal Backpack Load for Long Distance Hiking," by Shoenfeld, Y. et al. **J. Sports Med. Phys. Fitness** 17(2):147-51, June, 1977.

"Serum Glucose and Lactic Acid Concentrations During Prolonged and Strenuous Exercise in Man," by Udassin, R. et al. **Am. J. Phys. Med.** 56(5):249-56, October, 1977.

"Hikers' Hazards," by Glickman, F.S. **Cutis** 19(4):497-500, April, 1977.

"The Incidence, Importance and Prophylaxis of Acute Mountain Sickness," by Hackett, P.H. et al. **Lancet** 2(7996):1149-55, Nov. 27, 1976.

"Walking Speed as a Basis for Normal and Abnormal Gait Measurements," by Andriacchi, T.P. et al. **J. Biomech.** 10(4):261-8, 1977.

"Self-Paced Walking as a Method for Exercise Testing in Elderly and Young Men," by Bassey, E.J. et al. **Clin. Sci. Mol. Med.** 51(6):609-12, December, 1976.

"Oxygen Intake and Walking Speed Before and After Total Hip Replacement," by Arborelius, M.M. et al. **Clin. Orthop.** (121):113-5, November-December, 1976.

"Energy Expenditure During Walking in Patients Recovering from Fractures of the Leg," by Imms, E.J. et al. **Scand. J. Rehabil. Med.** 8(1):1-9, 1976.

"Peripheral Arterial Insufficiency, Effect of Physical Training on Walking Tolerance, Calf Blood Flow and Blood Flow Resistance," by Dahllof, A.G. et al. **Scand. J. Rehabil. Med.** 8(1):1976.

"Moving Patterns of Point of Application of Vertical Resultant Force During Level Walking," by Yamashita, T. et al. **J. Biomech.** 9(2):93-9, 1976.

"The Effects of Walking Velocity and Age on Hip Kinematics and Kinetics," by Crowinshield, R.D. et al. **Clin. Orthop.** (132):140-4, May, 1978.

"Energy Cost of Normal Walking," by Blessey, R. **Orthop. Clin. N. Am.** 9(2):356-8, April, 1978.

"Predicting Metabolic Cost of Level Walking," by Zarrugh, M.Y. et al. **Eur. J. Appl. Physiol.** 38(3):215-23, Apr. 15, 1978.

"Muscular Efficiency During Steady-Rate Exercise. II. Effects of Walking Speed and Work Rate," by Donovan C.M. et al. **J. Appl. Physiol.** 43(3):431-9, September, 1977.

"Predicting Energy Expenditure With Loads While Standing or Walking Very Slowly," by Pandolf, K.B. et al. **J. Appl. Physiol.** 43(4):577-81, October, 1977. □



THE JOURNAL'S WALKER-HIKER MODEL IS NONE OTHER THAN FORMER MANAGING EDITOR LESTER H. MILES, seen here on Sept. 17, 1978 at the toe of Athabasca Glacier in the Columbia Icefield in Alberta, Canada. Mr. Miles is a longtime member of the Mountain Club of Maryland.

(Photograph courtesy of Lester Miles.)

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of October, 1978:

1. Videocassettes in the field of Otolaryngology	92 citations.
2. Urticaria pigmentosa or mastocytosis	30 "
3. RAST allergy testing	36 "
4. Polycythemia vera with lymphocytic leukemia	45 "
5. Hypophosphatemia	50 "
6. Adverse effects of Valium	68 "
7. Amylase content in lymph tissues	44 "
8. Renal transplantation in sickle-cell anemia	3 "
9. Relationship between platelets and endotoxin	36 "
10. Vitamin D and bones	21 "

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
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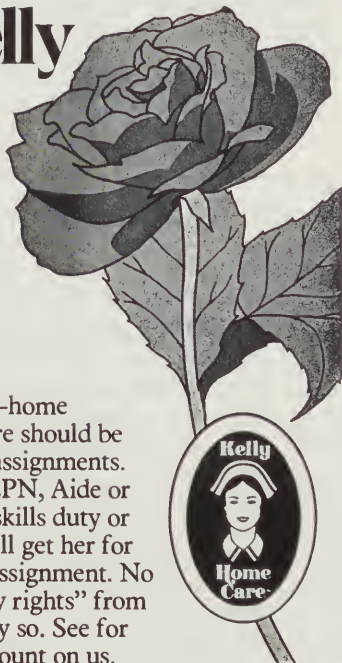
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Rehabilitation Medicine

Laboratory Differentiation of Stroke and Intracranial Mass Lesions

By LEON REINSTEIN, MD

Dr. Reinstein is Assistant Professor in the Department of Rehabilitation Medicine of the University of Maryland School of Medicine, 22 S. Greene St., Baltimore, MD, 21201, where he can be contacted for reprint and other data.

Introduction

We have previously presented the case of a stroke patient transferred to a rehabilitation center who was subsequently found to have an operable intracranial meningioma.¹

This report reviews the pathophysiologic basis for the use of the brain scan, echoencephalogram, skull X-ray, electroencephalogram, lumbar puncture and computerized axial tomography (the CAT Scan), in the diagnostic evaluation of the stroke patient suspected of having an intracranial mass lesion (ICML).

Brain Scan

Normally the blood-brain barrier prevents a radioactive drug from diffusing into the brain. In cerebral tumors, recent cerebral infarctions, subdural hematomas and brain abscesses, there is a change in the permeability of the blood/brain barrier and/or increased vascularity, which results in abnormal regional accumulations of radiation demonstrated by scintillation scanning.²

Cerebral Infarction is characterized by an abnormal area of increased uptake of radioactivity which follows a familiar anatomic distribution coinciding with an area of the brain served by a principal nutrient artery (e.g., the middle cerebral). In 80% of the cases, this is seen four-seven days after the onset of the stroke. Occasionally, the scan may be abnormal earlier, reflecting increased perfusion of tissue surrounding the infarct. In either case, the abnormal area will decrease in size by six weeks and should return to normal by three months; 75% of patients with a cerebral infarction will have an abnormal brain scan.³

A **Cerebral Tumor** or **Brain Abscess** characteristically produces a round or irregularly lobulated area of abnormal activity. A repeat scan done after several weeks will show an increase in size; 80% of brain tumors will have an abnormal scan.³

A unilateral **Subdural Hematoma** characteristically produces a crescent-shaped increase in the thickness of the vascular rim on one side of the skull, usually seen only on the anterior-posterior projection. As with infarction, these changes are usually seen first four-to-

seven days after the onset of the subdural hematoma. With time, there may be an increase in size or resolution.⁴

Thus, a progressive increase in size of the affected area on serial brain scans suggests an ICML. An initial normal scan followed by an abnormal scan shortly thereafter, a decreasing abnormal uptake on serial scanning, and the specific anatomic location of the abnormality help confirm the diagnosis of a cerebrovascular accident.

Echoencephalography

Almost all cerebral tumors, unilateral chronic subdural hematomas and brain abscesses cause a displacement of the midline intracranial structures which produces a significant shift of the midline echo toward the side opposite the lesion. Only one-third of cerebral infarctions have a significant midline shift, however, midline shifts due to cerebral infarction usually have a lower value (mean of 4-5 mm.) compared to shifts due to ICML (mean of 7-9 mm.) Mass lesions located in the occipital-temporal region of the posterior fossa, and bilateral chronic subdural hematomas, do not produce a midline echo shift.⁵

Abnormal echoes may occur at the interface between the surfaces of the brain and a tumor, abscess wall or blood accumulation. These are frequently seen in chronic subdural hematomas (85%) and occasionally seen in tumors (25%) and abscesses (25%). They are not seen in cerebral infarction.⁵

Thus, echoencephalography which reveals a 7-9 mm. shift of the midline echo, or abnormal echoes, is highly suggestive of an ICML.

Skull X-rays

Routine skull X-rays demonstrate significant abnormalities in over 70% of ICMLs. After one-four months of increased intracranial pressure, decalcification of the sella turcica occurs. This is found in 30% of cerebral tumors and brain abscesses.⁶

The pineal gland is calcified in 60% of adults. A 3 mm. displacement from the midline of the calcified pineal gland is found in 25% of supratentorial masses. However, this displacement may also be present in massive cerebral infarction and in cerebral hemorrhage. Also, a calcified pineal gland may appear midline in bilateral subdural hematomas, a subdural hematoma

less than 100 cc. in size, or one which is subfrontal, temporal or infratentorial.⁷

The combination of decalcification of the sella turcica and a displaced pineal gland on skull X-ray is strongly suggestive of an ICML.

Other less common abnormalities which may be seen on skull X-ray include intracranial calcification and bony erosion in a cerebral tumor; a fracture line and bony erosion in a chronic subdural hematoma; a fracture line, otitis, sinusitis and mastoiditis in a brain abscess and vessel calcification in cerebral infarction.^{3, 7}

Electroencephalography (EEG)

There are abnormal EEG findings in most cases of cerebral infarction and ICML. Seventy-five percent of **Cerebral Infarctions** demonstrate suppression of the alpha rhythm (frequency 9-11 cps). Half of these abnormal EEGs will return to normal in one-two months; 10-25% will develop sharp waves indicating an irritative focus.⁸

Eighty percent of **Cerebral Tumors** will demonstrate a delta focus (frequency < 4 cps) which becomes more prominent on serial examination; 25% also have sharp waves. The tumor itself does not give rise to the abnormal electrical activity. Rather, the tumor produces metabolic abnormalities in the adjacent neurons, probably secondary to edema, and these neurons produce the electrical abnormalities seen.⁸

More than 90% of **Subdural Hematomas** and **Brain Abscesses** demonstrate progressive alpha suppression and generalized delta waves. They can be differentiated by the very low (40uv) amplitudes seen in a subdural hematoma and the very high (500 uv) amplitudes seen in a brain abscess.⁸

Thus, the findings of delta waves and progressive abnormalities on EEG suggest an ICML.

Lumbar Puncture

A **Cerebral Infarction** usually produces a normal cerebrospinal fluid which is clear and colorless, has 0-5 lymphocytes or monocytes, but no red cells or polymorphonuclear leukocytes, and normal protein and pressure values.⁷

A **Brain Tumor** usually produces non-specific elevations in protein and pressure which may also be seen in massive cerebral infarction, brain abscess and chronic subdural hematoma. Various authors have been able to find tumor cells in the cerebrospinal fluid of only 25% of patients with brain tumors.^{9, 10} They stress that neoplasms not having direct contact with the ventricular or ependymal surface will have a negative spinal fluid cytology.

A **Chronic Subdural Hematoma** may produce spinal fluid that is either xanthochromic (50% of cases) or bloody (10%). Xanthochromia indicates that bleeding occurred more than two hours, but less than four weeks previously. Bloody or xanthochromic cerebrospinal fluid may also be seen in hemorrhagic infarction, late cerebral embolism and most cases of intracerebral hemorrhage and subarachnoid hemorrhage.⁷

A **Brain Abscess** usually demonstrates an increased number of polymorphonuclear leukocytes and lymphocytes. However, this may also be seen in a cerebral infarction which occurs near the subarachnoid or ventricular space.⁷

Meningovascular syphilis, paresis and a gumma may all present signs and symptoms suggestive of cerebrovascular disease. As 10-15% of patients with active neurosyphilis have a non-reactive blood serum, spinal fluid serology may be the only method of making a definitive diagnosis of neurosyphilis.⁸

Thus, except for the rare case of neurosyphilis, the cerebrospinal fluid findings in cerebral infarction, cerebral tumor, chronic subdural hematoma and brain abscess are usually non-specific and of limited value in differentiating a cerebrovascular accident from ICML.

However, the risks of performing a lumbar puncture in a patient suspected of having an ICML are substantial. There is danger of cerebral trans-tentorial or cerebellar parafoveal lobular herniation and death due to the presence of increased intracranial pressure. Stuteville and Welsh¹¹ had two sudden deaths during lumbar puncture in 42 patients with subdural hematoma. Frankel and German¹² reported two fatalities directly attributable to lumbar puncture among 219 patients with glioblastoma multiforme. It is noteworthy that these herniations are the usual pathophysiological mechanism of death in most cases of cerebral tumor, subdural hematoma and brain abscess.

Thus, lumbar puncture is of limited value and carries a significant mortality in the stroke patient suspected of having an ICML. Its cautious use is recommended only when neurosyphilis is suspected.

Computerized Axial Tomography (CAT Scan)

This is a new, noninvasive radiologic technique developed in England¹³ and first used in the US in 1973.¹⁴ A narrow beam of x-rays traverses a 13 mm. slice of skull and brain producing 28,800 data points per slice. Each data point represents a tissue segment 3 X 3 X 13 mm. The 28,800 readings are processed by a computer and relative absorption coefficients are calculated. These values are fed to a cathode ray tube and a picture is generated in which the brightness of each point is proportional to its absorption coefficient. A photographic print is then made of the picture clearly showing the skull, gray matter, white matter, ventricles and subarachnoid spaces.¹³

Disease processes are seen as changes in the capacity of the tissues to absorb X-rays producing alterations in density. Increased density (white areas) are found in clotted blood, calcium deposits and dense fibrotic tissue. Decreased density (dark areas) are found in tissue necrosis, edema, cyst formation and unclotted hemorrhage. These findings are often accompanied by distorted anatomy, particularly displacement of the midline structures.¹³

Cerebral Infarction initially produces a diffuse, low density, necrotic area involving the cortex gray and

white matter. By two-four weeks, the area of necrosis is more sharply defined and there may be a central area of increased density due to hemorrhagic alterations. Resolution proceeds during the next four-five months with disappearance of the edema, hemorrhagic tissue and necrotic tissue; decrease in size and finally formation of a lacuna similar in density to cerebrospinal fluid.¹⁵

A **Cerebral Tumor** may demonstrate an area of increased density due to viable tumor tissue, calcification or hemorrhage into the neoplasm. An area of decreased density may also appear due to edema of the adjacent brain, cystic fluid within the tumor or tissue necrosis. Displacement of the ventricular system is usually present due to the mass effect.¹⁵ Paxton and Ambrose¹⁶ studied 232 patients with cerebral tumors, and the CAT Scan was abnormal in 194 patients (85%). Zelch et al.¹⁷ detected three unsuspected tumors by CAT Scan among 51 patients suspected of having cerebrovascular disease.

A **Brain Abscess** will show a well-circumscribed area of decreased density secondary to necrosis and edema.¹⁸ There may also be displacement of the midline structures.¹⁶

An **Acute Subdural Hematoma** will produce a crescent-shaped area of increased density located along the convexity of the brain with displacement of the midline structures to the contralateral side. However, identification of a Chronic Subdural Hematoma may be more difficult. As the clot ages, much of the material is absorbed and it may become less and less dense until its density equals that of the adjacent brain and the area appears normal. Finally, after significant absorption, an area of decreased density will be seen. The midline structure displacement usually persists.¹⁸

Thus, early studies indicate that CAT Scans are helpful in differentiating ICML from a cerebrovascular accident. A progressive process and significant midline structure displacement suggest an ICML.

Summary and Conclusions

1. The brain scan, electroencephalogram, skull X-ray, echoencephalogram and computerized axial tomography (CAT Scan) are safe, non-invasive procedures which provide valuable information in the differentiation of a cerebrovascular accident from an intracranial mass lesion (ICML).

2. Specific abnormalities which suggest an ICML include:

- A progressive increase in the size of the affected area seen on brain scan.
- A 7-9 mm. midline shift and abnormal echoes observed on echoencephalography.
- Decalcification of the sella turcica and displacement of the pineal gland noted on skull X-ray.
- Delta waves and progressive abnormalities on electroencephalography.
- A progressive process and significant midline structure displacement seen on computerized axial tomography (CAT Scan).

3. The Cerebrospinal Fluid findings in a cerebrovascular accident and ICML are usually non-specific and of limited diagnostic value. Furthermore, there is a significant mortality associated with lumbar puncture in patients with an ICML. Therefore, lumbar puncture is not recommended in the diagnostic evaluation of the stroke patient suspected of having an ICML, unless neurosyphilis is strongly suspected.

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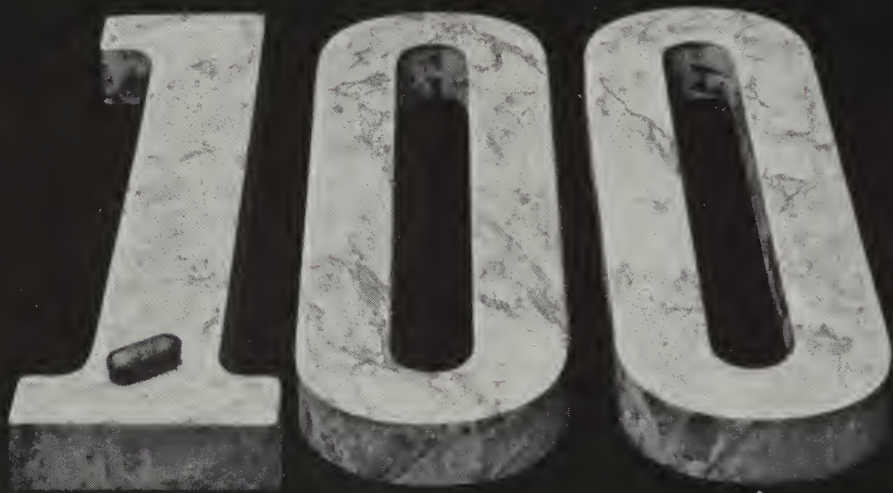
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Health in History

Update:

The Hohenzollerns, Field Marshal Rommel, Benito Mussolini and Count Galeazzo Ciano

By BLAINE TAYLOR

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Introduction

Since September, 1975, the *Journal* has been publishing an award-winning series of articles describing how health has played a significant part in the shaping of international political events and history.

Periodically, in addition to the fullscale studies offered (19 to date), there will be special "update" pieces to acquaint the readership with new or hitherto-undiscovered aspects or sources relating to medical case histories already detailed in previous issues. The first such update appeared in the April, 1977 edition of the *Journal*, concerning the Kennedy family and Alabama Governor George C. Wallace.

It is hoped that this practice will serve reader continuity of understanding of the series overall.

The Hohenzollerns

The June, 1976 *Journal* featured a **Health in History** cover story entitled **The Hohenzollern Kaisers: A Medical Casefile**, which was a rather detailed look at the cancer and other health problems of Kaisers Wilhelm I, Frederick III and Wilhelm II and Kaiserin Victoria of Imperial Germany (see following Table 1.)

The following year, two new studies of the Kaiser of World War I appeared: a fullscale portrait, **The Last Kaiser: A Biography of Wilhelm II, German Emperor and King of Prussia**, and the autobiography of his only daughter and sole surviving child (of seven; see Table 2), **The Kaiser's Daughter: Memoirs of Her Royal Highness Victoria Luise, Princess of Prussia**.

Table 1: Partial Hohenzollern Family Tree

- | |
|---|
| 1) Kaiser Wilhelm I
(1797-1888; ruled 1861-1888) |
| 2) Kaiser Frederick III
(1831-88; ruled March-June, 1888) |
| 3) Kaiser Wilhelm II
(1859-1941; ruled 1888-1918) |
| 4) Crown Prince Wilhelm
(1882-1951; abdicated 1918) |

—Table by Blaine Taylor

The medical findings of these two works, plus those of two other sources—**The Kaiser and His Court** (from the papers of German Admiral Georg Alexander von Müller) and Denis Judd's **Eclipse of Kings: European Monarchies in the 20th Century**—have been combined to add the following details to the *Journal's* earlier study of this ill-fated dynasty.

Fritz and Vicky

On Apr. 24, 1916—during the height of the First World War



KAISER WILHELM II AND KAISERIN AUGUSTE VIKTORIA at Bad Homburg in 1917, during World War I.

Table 2: The Family of Kaiser Wilhelm II

Six Sons		
Crown Prince Wilhelm ("Willie") 1882-1951	Prince Eitel-Frederick ("Fritz") 1883-1942	Prince Adalbert 1884-1948
Prince August Wilhelm ("Auwi") 1887-1949	Prince Oskar 1888-1958	Prince Joachim 1890-1920
Daughter		
Princess Viktoria Louise 1892-		

fighting on the Western Front in Europe—Adm. von Müller, Chief of the German Naval Cabinet, wrote in his diary at Kaiser Wilhelm II's military headquarters at Charleville in German-occupied France: "This evening, while we were standing about after dinner, the Kaiser told us some unpleasant details of his relationship with his parents during his father's illness. The Empress Frederick emerged in an exceedingly bad light."¹

This notation—made about events that occurred 28 years earlier—concerned the death from throat cancer of his father, the unfortunate Kaiser Frederick III, who ruled for a mere 99 days in 1888, after the demise of his father, Kaiser Wilhelm I at age 90 the same year.

Tyler Whittle, author of *The Last Kaiser*, points out that the

English physician Sir Morell MacKenzie diagnosed then-Crown Prince Frederick (in 1887) as having syphilis (according to attacks being printed at that time in the French press), and this was confirmed by a German Dr. Schmidt of Frankfurt "by prescribing the accepted cure for syphilis."²

During 1888-1901, the widowed Empress Frederick (Kaiserin Victoria) lived a shadow existence, while her son ruled in her dead husband's place. A liberal Englishwoman (she was the daughter of Queen Victoria), "Vicky" had always been unpopular in Germany. During the Franco-Prussian War of 1870, she'd established a combat hospital behind the German lines, but "Her hospital found little favor with the German medical profession. She was told that English

methods were not suitable."³

She had outraged German medicine twice in her life, by employing English—not German—medical advice during the birth of her eldest son (1859) and her husband's terminal illness, and herself died of cancer with a British physician in attendance on Aug. 5, 1901.

"Kaiser Bill"

Allied propaganda of World War I depicted Wilhelm II as both a buffoon (nicknamed "Kaiser Bill") and as a grasping, all-powerful Supreme War Lord (his official German title); neither portrait was near the mark, however. First, when war came in 1914, he tried to prevent it and, second, soon after hostilities commenced, the Emperor lost control of his war machine to his generals. As he once told his last Imperial Chancellor, Prince Max of Baden, "If people in Germany think I am the Supreme Commander, they are grossly mistaken! The General Staff tells me nothing and never asks my advice. I drink tea, go for walks and saw wood . . ."⁴ Later, in 1917, he exclaimed, "I am only Hindenburg's adjutant and I have nothing to say."⁵

The reasons for the Kaiser's displacement in power were twofold: first, he didn't really *want* the responsibility, and second, his prior inconsistency in matters of state was notorious, a visible part of his nervous, unstable temperament: "He had no fixed policies, no sober personal philosophy to give him direction and, as he lurched from one 'initiative' to another, the ship of state lurched with him."⁶ The Kaiser's impact on the course of the war was, overall, negligible."⁷

During the four-year passage of the war, as we shall see, the Kaiser suffered from a host of both minor and some major physical problems. At least some of these derived from his boyhood, such as his propensity for catching the common cold. When he was three, his mother wrote of him:

William has inflamed eyes and is shut up in his room, which makes him look like a cheese. His eyes discharge a good deal of matter and are swollen; he had this before (five months previously, but it was only one eye then and now it is both.) Wegner says it proceeds from cold."⁸



THE KAISER'S DAUGHTER, PRINCESS VIKTORIA LOUISE, (left) riding on the Tempelhofer Field in Berlin in 1911 with her brothers, Prince August Wilhelm (center) and Crown Prince Wilhelm (at right, turning in the saddle.)

A biographer adds, "It was not only a question of colds. The ordinary course of childhood ailments, which (his brothers) Charly and Harry shrugged off so cheerfully seemed so much worse when he caught them."⁹

During World War I, Adm. Müller noted in his diary that the Kaiser suffered from colds on Feb. 4, 1917 ("severe") for which he took "a Turkish Bath cure" and on Jan. 15, 1918: "The naval report was cancelled this afternoon because His Majesty has retired to bed. . ." He further noted when Wilhelm caught "chills," such as on Dec. 5, 1914,¹² Feb. 3, 1916,¹³ again on Feb. 13th ("very bad") coupled with tonsillitis,¹⁴ on Nov. 7, 1916 (when the Kaiser felt he was close to having pneumonia)¹⁵ and yet again on Nov. 15, 1917.¹⁶

To forestall these recurrent colds and chills, the Kaiser, in pre-war days, took some unusual measures, as one of his biographers notes:

"She also found his dread of infection inconvenient because, at the discovery of measles or mumps in the palace, he would at once move elsewhere and at half an hour's notice everyone had to follow. On one occasion, the Court was settling into the Bellevue Palace for the winter instead of the Old Palace in Berlin—a change of plan welcomed by everyone—when Prince Oscar, who had just returned from Italy, went down with chickenpox. All the repacking and moving to another palace proved fruitless because no sooner had they arrived in their new refuge than Prince August William went down with the same disease. Again there was uproar. As if this sudden flight was not bad enough, it was discovered it had been quite unnecessary. Lack of communication had caused the Kaiserin to insist on the moves for the Kaiser's sake, but afterwards to everyone's vexation and surprise, he announced that in fact he had had chickenpox years before and had simply done what the doctors had ordered."¹⁷

On Apr. 20, 1917, Von Müller noted in his diary the Kaiser's "grossly overheated bedroom"¹⁸ and that His Majesty ". . . sat up in bed and confessed that he had not slept a wink for six nights."¹⁹ The Kaiser often would use his inability to sleep or the uncomfortableness of military headquarters as excuses to retreat personally further from the war zones and enjoy a life of ease in the rear areas.²⁰⁻²¹ The overall impression that this left on even his closest associates was one of Imperial indolence ("The Kaiser declared

that he could not see the Chancellor tomorrow before six o'clock. He wanted to spend the morning in the gardens of Sans Souci and he must sleep after lunch,")²² in the face of mounting crisis on the combat fronts both East and West. By Aug. 16, 1917—with the end of the war more than a year away—Von Müller wrote of the Kaiser's rela-

tions with his top military commanders: "He is now completely left out in the cold. . . because he has failed in his duty. . ."²³ As early as Apr. 18, 1915, he noted a bizarre medical plot against the Kaiser's lack of wartime leadership: "Valentini. . . confided to me that the Kaiser's physician, Dr. von Neidner, is worried about an intrigue at Head-



GERMAN CROWN PRINCE WILHELM IN THE 'THIRTIES, wearing the uniform and shako of the Death's Head Hussars, in which he was buried in 1951. Nicknamed "Little Willie" and "the Greyhound" (because of his slender figure), his extramarital affairs discredited the Hohenzollern Dynasty.

quarters to declare the Kaiser temporarily incapable of ruling and to make the Crown Prince Regent. A wild pipe dream!"²⁴ After the war's loss—when editing his diaries for eventual publication following the death of both himself and the Kaiser—Von Müller added to his passage: "I heard no more of the matter at the time. It never became dangerous and never presumably got further than private talk."²⁵

Oddly enough, Wilhelm was neither indolent nor disinterested in the war's outcome. As regards the first, he was, physically, an extraordinarily active man. Before the war, "Every afternoon, when the Kaiser was at home, he walked with the Kaiserin, and he shot, rode, drove, hunted, boated, skated and tobogganed with. . . energy."²⁶ As early as January, 1915 (during the war), he was sawing wood for exercise,²⁷ and, indeed, in his postwar exile in Holland, felled 17,000 trees in his 60s.²⁸ Moreover, by all accounts, he was happy in his marriage to his first wife, the Kaiserin, and had a healthy sex drive that resulted in seven offspring (see Table 2).²⁹

Personally, he was physically courageous, too. On Apr. 25, 1916, French planes staged a bombing attack on Headquarters at Charleville, in which the engineer of the Imperial train was killed, but Wilhelm II remained there nonetheless.³⁰ He did, however—like most monarchs of his time—fear assassination³¹ (and with good reason: in November, 1900, "a demented old woman . . . threw an ax at him, but missed" and ". . . in 1903. . . a feeble-minded youth hurled a piece of iron at him and wounded him under the right eye."³² His fear of illnesses can also be found to have a rational basis, as, in 1866, his brother Sigismund died of meningitis³³ and his brother Waldemar 12 years later during a typhoid epidemic.³⁴ (As has earlier been seen, both his parents died of cancer, and he underwent a successful throat operation for it himself in 1904.)³⁵ Also, as was noted in the *Journal's* prior piece on the Kaiser,³⁶ his dislocated left arm (suffered at birth) hampered his ability to ride, walk, stand and even feed himself—although he managed to

do all these normally "taken for granted" things quite well even as a teenager³⁷ through rigorous training.

His seeming disinterest in the war sprang from his belief—developed early-on, possibly after the First Battle of the Marne in 1914—that Germany couldn't defeat the world. Despite this, however (and naturally) he wanted to believe his country would win, and would veer from making irrational statements about the German Army conquering all in its path, when, in fact, the news from the battlefields was bad, to ensuring that wounded English soldiers received the same medical treatment as wounded Germans.³⁸

This erratic behavior led some—even in his inner circle—to conclude that he was mad. Von Müller wrote on May 16, 1916: "His Majesty does not appear to be in his right mind."³⁹ In 1927, nine years after the war, Von Müller added that the Kaiser's bold speeches in the face of military defeat "Can only be explained by the presumption that the Kaiser's mental balance had been disturbed by the long, nerve-racking war."⁴⁰

In truth, the Kaiser's nerves were bad—and always had been, even before the war, which merely served as the catalyst to bring them to the attention of his officer corps, which—prior to 1914—had never observed Wilhelm at close quarters except on the annual Imperial Maneuvers.

"The medical profession states that men can and often do suffer the emotional stresses experienced by females in the menopause. If this was the case with the Kaiser, it would explain his increased nervousness and tension in his early middleage. Jan. 29, 1899 was his 40th birthday. He wrote to Queen Victoria that the strain of his office was 'often too heavy to bear' and described himself as 'her queer and impetuous colleague.' She noted in her journal: 'I wish he were more prudent and less impulsive at such an age!'"⁴¹

Wilhelm II was given (like Hubert Humphrey) to public weeping as when, in 1908, he almost abdicated the throne over an intemperate newspaper interview he'd granted,⁴² and again, eight years later, when he was forced to replace Gen. von Falkenhayn with Von Hindenburg.⁴³ As the war went on, his nerves worsened. He was ". . . difficult to live with. There was

no telling how well or ill he would be from day to day; no way of telling why the barometer of his moods moved up and down so rapidly, nor how long he would be in euphoria or depression. . ."⁴⁴ He suffered near-complete nervous breakdowns in April, 1917⁴⁵ and in October, 1918 (along with the Empress) when he realized for sure that the war was lost (and was walking with a cane due to sciatica.)⁴⁶

In addition to bouts of nervous depression, the Kaiser suffered during 1914-18 from "a slight heart attack" on July 9, 1916⁴⁷ (and another on Apr. 18, 1917,⁴⁸ a sore throat on July 17, 1916, a hernia operation in February, 1917⁵⁰ and an arthritic attack coupled with "rheumatic pains" in October, 1918.⁵¹

The effect of all these things—considering his past history—was, perhaps, predictable:

"The Kaiser, it is alleged . . . escaped into a world of fantasy. Certainly he began to rush about inspecting troops, distributing Iron Crosses in person and addressing parades with long speeches. His vigor and stamina were remarkable. He moved so fast that his generals could hardly keep pace with him and one, on a hot day, fainted with fatigue. He went as close to the front as Ludendorff permitted, driving through the shelled and burnt villages in a motorcar displaying the yellow Imperial standard. It was noticed that he had aged perceptibly. His hair had grayed, and his face had become lined . . ."⁵²

This was the situation at the war's end in November, 1918, when the Kaiser's generals and civil servants forced both him and his son, Crown Prince Wilhelm, to abdicate and seek asylum in neutral Holland. Civil war broke out in Germany as the military mutinied, the Hohenzollern Dynasty was overthrown and a Socialist Republic proclaimed.

Hohenzollern Twilight, 1918-79

During the later war years, the health of Wilhelm II's first wife—the Kaiserin Auguste Victoria (nicknamed Dona) also gave way. Von Müller confided to his diary on March 3, 1917: "The Empress looked very ill."⁵³ She was, in fact, suffering from a cardiac condition,⁵⁴ and had a stroke on Aug. 18, 1918.⁵⁵ Despite her illness, how

ever, she was courageous enough to face down the Red revolutionaries when they came to the New Palace at Potsdam near Berlin during the Revolution of November 1918 (no mean task when one considers the murder of the Tsar and his family in Russia by the Reds!)⁵⁶

During the final days of the war, the Kaiser had spent three weeks away from Headquarters to care for his ailing wife,⁵⁷ and their eventual reunification in exile in Holland brought them even closer together, but the suicide death by shooting of their youngest son, Prince Joachim, 30, on July 18, 1920⁵⁸ aggravated her already-serious condition and she died on Apr. 11, 1921.⁵⁹

In the midst of his travail, it's no wonder the Kaiser himself didn't think of suicide, but he'd earlier rejected it as "...an abnegation of duty and a pathetic and sinful means of escape. . ."⁶⁰ In 1922, ill in bed, he wrote his daughter: "Lying alone and miserable. . .a frugal pleasure which doubles the severity of loneliness, in that one lacks the true devotions of a woman. . ."⁶¹ Later that year, he married a widow 24 years younger than himself, Princess Hermine von Schoenau-Carolath.⁶² The Kaiser lived happily with her for almost 20 years until his death at age 82 on June 6, 1941;⁶³ Princess Hermine died six years later of a heart attack while in Soviet captivity following World War II.⁶⁴

The Kaiser's younger brother, Prince Heinrich—an Admiral in the Imperial German Navy—died in 1929 at age 67.⁶⁵ (Two of his three sons had hemophilia, the disease that—as we shall see in a future article—helped cause the downfall of the Romanov Dynasty in Russia.)⁶⁶

One by one, following the tragic death of Prince Joachim, the Kaiser's remaining five sons perished: Hitler-Frederick ("Fritz"), 59, in Potsdam in 1942,⁶⁷ Prince Adalbert, 64, in 1948 in Switzerland,⁶⁸ Prince August Wilhelm ("Auwi," a Nazi sympathizer), 62; Crown Prince Wilhelm, 69, of a heart attack in Germany⁶⁹ and Prince Oscar, 70 (who'd suffered a nervous breakdown in October, 1915),⁷⁰ in Munich on Jan. 27, 1958 (his fa-

ther's birthday.)⁷¹

Today, of his seven children, only the Kaiser's sole daughter—Victoria Luise, 85, Princess of Prussia—remains. Her own husband—Ernest August, Duke of Brunswick—died in 1954.⁷²

Field Marshal Rommel

The very month (October, 1977) that the *Journal's* case study—**Field Marshal Erwin Rommel: The Desert Fox**—appeared, there was also published the first real, fullscale biography since the late Desmond Young's controversial 1950 portrait, **Rommel: The Desert Fox**. This was British revisionist historian David Irving's **The Trail of the Fox: The Search for the True Field Marshal Rommel**. Earlier in 1977, Irving had published his **Hitler's War** amid a storm of criticism over some of his conclusions concerning exactly who in the Nazi hierarchy (Hitler or Himmler, or both) had ordered the extermination of the Jews in Europe. The resultant publicity surrounding **Hitler's War** completely obscured the fact that a new Rommel biography was about to appear. Had I known this, I certainly would've delayed my own work in order to include the results of Irving's medical research work on Rommel. When the book did appear, it, too, generated controversy, as shown in this Reuter's dispatch from London:

"Rommel, the legendary Desert Fox who was Germany's most famed World War II general, is depicted in a new book as an artless man who often raged at his colleagues and was prone to chronic moods of self-pitying defeatism.

"He was also firmly loyal to Hitler, even though he put his views outspokenly to him. And he was not part of the plot to assassinate the German Führer on July 20, 1944, the book says. Rommel poisoned himself on learning he had been implicated by others in the plot."⁷³

Medically, however, the book did **not** contradict any of the *Journal's* own findings on Rommel as a patient, and the historical implications that his illnesses had weren't challenged, either.

The book did, however, add some detail to the Field Marshal's casefile not presented in the *Journal's* coverage, such as that he'd broken his right ankle in 1907 "jumping over a stream"⁷⁴ and that before the German Army accepted

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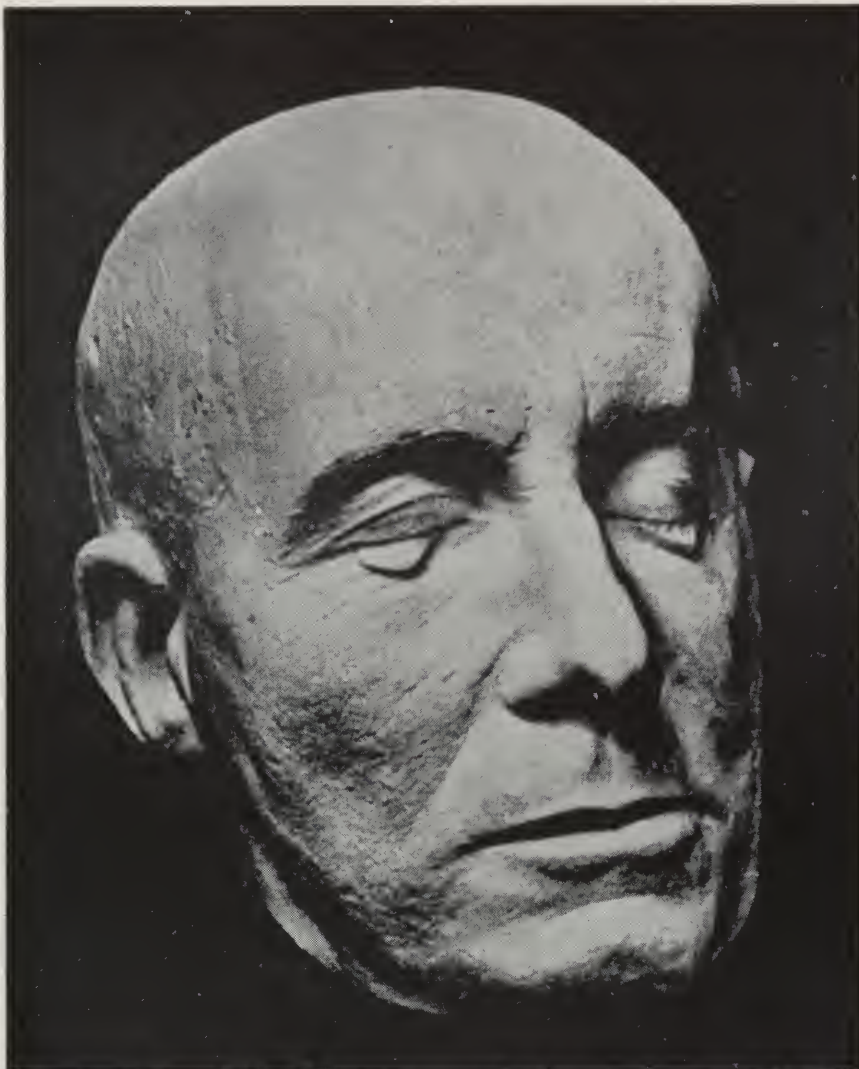
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(Left) ROMMEL'S DEATH MASK (from *Rommel: The Desert Fox*, by Desmond Young.) (Middle—Lying-in-state, from David Irving's *The Trail of the Fox: The Search for the True Field Marshal Rommel*.) Bottom—Rommel's signature.

him for service in 1910, his father had to arrange and pay for an operation for inguinal hernia for his son.⁷⁵

During the Polish campaign of 1939, Irving reports, Rommel—then Commandant of Hitler's military headquarters in the field—'Noticed the first heart complaints and once he felt distinctly faint. He has told nobody but Lucie (his wife—ed. note.) She has sent him a big packet of Lecithin medicine.'⁷⁶ In February, 1940, when Hitler appointed him to an active 'divisional command, Rommel took up 6 AM jogging to get back into good physical shape' (he was almost 50.)⁷⁷

In July, 1941, when he felt ill and his wife urged him to see a doctor, states Irving, Rommel replied: "I don't trust doctors. In 1915, they wanted to amputate my leg!"⁷⁸ In 1944, while awaiting the D-Day invasion of France, Irving says Rommel suffered "a return of his old lumbago trouble."⁷⁹

Finally, Irving supplies the first name—Georg—of a man (Gen. Stumme) that Rommel was to succeed and be succeeded by at two important points in his career—something no other Rommelian author had been able to do.

The publication of the *Journal's* Rommel piece touched off a worldwide demand for the article that continues. Favorable letters concerning it were written by Baltimore Mayor William Donald Schafer and West German Navy Freigattenskapitan (Frigate Capt.) Hans J. Schafer, Commandant of the destroyer *Rommel*.

Capt. Schafer wrote the *Journal* "Since January (1978), my ship is in the shipyard (at Kiel, West Germany—ed. note) for a short overhaul, so I had time for studying your very interesting article I have read, of course, a lot about the Field Marshal, and most of the reference in your article are well-known to me. Nevertheless, I discovered a lot of new details and found new contexts and interesting connections. I also discovered small misrepresentation. On page 41, you mentioned that Rommel by-passed the grade of Brigadier General and jumped from Colonel to Major General. In the former Wehrmacht, there was not a rank

of Brigadier General, so it was quite normal to be promoted from Colonel to Major General.”⁸⁰

The *Journal* article is now on deposit in the ship’s library.

The Duce (Leader) as Patient

The *Journal*’s inaugural *Health in History* article, published in September, 1975, was *Benito Mussolini: A Medical Case History*, followed by a brief update—*Mussolini Revisited*—in the July, 1976 edition. Since that time, the English language versions of the memoirs of both his widow, Rachele Mussolini (*Mussolini: An Intimate Biography*) and eldest daughter, Countess Edda Mussolini Ciano (*My Truth*) have become available to me throwing new (but not contradictory) light on the *Journal*’s initial findings concerning the Duce’s case, plus some interesting sidelights on his son-in-law and Italian Foreign Minister Galeazzo Ciano.

In April, 1926, after he’d presided over a medical gathering at the Capitol in Rome, Englishwoman Violet Gibson fired five revolver shots at Mussolini, and one of the bullets wounded him in the nose. As he later told his wife, “You know, Rachele, it wasn’t the Englishwoman who nearly killed me, but the doctors! I was unlucky. It was a medical congress, and a score of them jumped on me, all hoping for the honor of saving Mussolini. I was afraid I’d never survive in the crash and had to fight my way out with fists!”⁸¹ On Oct. 31, 1926, “a young man fired at him and missed. . . His escape from death had been slender. Not until we were traveling home did he notice the scorch marks on his jacket, and at the Villa Carpena, I noticed blood on both vest and shirt. A bullet, grazing the skin above his heart, had been deflected by a notebook.”⁸²

Mussolini, as his widow points out, had always led a life tinged with physical danger, especially in his early pre-World War I days as a Socialist agitator, when he literally crossed swords in order to save his life: “Each time Benito disagreed with anyone—a political opponent or even a friend—the argu-

ment had to be settled on the dueling field, strictly following the correct code of conduct. My husband must’ve fought a dozen times. . . (once) Benito came home without the bottom of one ear and with his shirt soaked in blood.”⁸³ His daughter remembers the young Mussolini was also constantly involved in scuffles with the local police: “He often returned home with his clothes crumpled and creased, his derby hat battered and dented by the clubbings he had received from policemen. . . I recall that, years later, after he came to power, a police officer requested an audience. Once inside my father’s office, the officer showed him an enormous truncheon and said in a quavering voice, ‘Your Excellency, would you do me the honor of accepting this gift? It is the club with which I often hit you at Forli during the demonstrations!’ ”⁸⁴

“During the First World War, when Mussolini served in the Italian Army as a frontline soldier against the Austrians, he was severely wounded”⁸⁵ by the accidental explosion of a mortar shell in his trench. Reports his daughter, “He kept a daily journal that he always carried on his person. This journal saved his life when a shell exploded at his feet and the book’s binding stopped one of the pieces, which would otherwise have pierced his heart.”⁸⁶

While in a military hospital, the future Duce had two memorable experiences. The first was a tempestuous clash between his common-law wife, Rachele, and a former Austrian mistress, Ida Dalser. As Rachele recalls, Dalser “. . . jumped on me, hurling insults and saying, ‘I am Mussolini’s wife. I am the only one who has the right to be with him.’ The other patients found this performance highly-amusing. I was furious. I lashed out with fists and feet and even began to squeeze my hands about her neck. Benito was so trussed up in bandages that he could hardly move, and, in trying to stop us, he fell to the floor. Luckily, the hospital staff intervened, or I would’ve strangled her.”⁸⁷ (Rachele decided to marry Benito, Edda reports, to forestall such a future scene, but the

husband-to-be wasn’t present, as he was “. . . bedridden in a military hospital with viral hepatitis. . . One of his friends, a music professor, Maestro Limenta, stood in as proxy. . . ”⁸⁸

The second in-hospital occurrence of note for Sgt. Mussolini’s future career was that he was visited by Italy’s King Victor Emmanuel III of Savoy, the monarch who appointed him to head his government in 1922 and removed him from power 21 years later. They’d met before, when Mussolini was in the hospital “being treated for paratyphoid.”⁸⁹

After the war, Mussolini suffered an auto accident in 1919. (His wife writes, “Though hurled for some yards, Benito escaped with only bruises and shock.”⁹⁰ Two years later, the now-budding Fascist politician crashed in a plane while taking flying lessons, suffering a broken knee.⁹¹

The Duce, his daughter remembers, was a “chicken-hearted” patient (as was her husband, Count Ciano):

“It has often been said that courageous men who confront danger and death without flinching are terrified of small bruises or minor illnesses. My husband was just like that. The moment he felt the slightest pain he believed that he was certainly going to die, and the slightest headache was instantly transformed by his imagination into a brain tumor. Once he even tried to convince me that a contagious illness could be caught on the telephone. I found this hilarious, especially since I had always felt that a little dust around the house was healthy because it inured one to microbes. When he felt ill, what a spectacle! And everyone knew of it, of that I can assure you.

“I don’t know which of the two, my father or my husband, was more of a mollycoddle. My father could not stand remaining in the room with someone who was coughing. He would immediately see the microbes spreading throughout the house, and when he was sick we were forbidden the threshold of his bedroom. He who had suffered the worst tortures when he had been riddled with shrapnel during the First World War, who had crashed in his plane, who had had one day been thrown from his car and who had fought so many duels, became stiff with terror when he had to have an injection—in fact, one time he stiffened so much that the needle broke! It was equally difficult to give him medicine, and I remember an incident that remained famous in the family annals.

“We were still living in Milan at the time, and my father had some medical treatment or other to follow. My grand-



(left) **THE DUCE (Leader)**, 1940-44. (Top, far left) with Hitler in Florence, Italy on Oct. 20, 1940 and (right, top) at the Fuhrer's Winnitz military headquarters in the Ukraine, summer, 1941. (Both photos previously-unpublished from the Heinrich Hoffmann Albums in the National Archives, Wash., DC.) Middle—With Hermann Goering (right) at the Germans' Rastenburg HQ in East Prussia after being rescued by the SS following his fall from power, September, 1943. (Hoffmann picture.) Bottom—With his German doctor (left) in Italy, 1944, Georg Zachariae ((from *Life's World War II: The Italian Campaign*.)

mother, mother and I had to put on a real performance! My mother filled the spoon, held it out to my father, then we three opened our mouths and said, 'Ahhh!' while Papa swallowed the potion. I don't know what got into me that day, but seeing my father with his mouth gaping open in disgust after having taken the medicine, gave me the impulse to slap his face ever so lightly. We were both equally astounded by my gesture.

"My father looked at me severely, pointed to one of the corners of the room, and said in a curt voice, 'Stand in that corner for one hour!' . . . That was, I believe, the only time that someone in the family had ever dared to raise a hand against my father.

"I never would have dared to do such a thing to Galeazzo. First of all, I understood that I owed my husband too much respect to indulge in such a gesture; secondly, he would certainly not have exhibited the same gentleness as my father, but would have immediately slapped me back—and hard!"⁹²

(Both Mussolini and Ciano, Edda states, were rabid male chauvinists.)⁹³

Once, Rachele urged Benito to have an unsightly wart on the back of his head, near his neck, removed. "Count Pulle, a doctor friend, wanted him to have it removed. 'It's nothing, Duce,' he told him. 'It'll only take a few minutes. Have it removed. It's not nice to look at.' 'Nice or not, I don't care,' replied Benito. 'This wart is a great delight to my children and grandchildren. My greatgrandchildren will find it, too, if it stays where it is.'"⁹³ The Duce's wart remained.

Home Life of a Dictator

Rachele's first-person memoir is full of detail concerning the Duce's domestic moments. Once, before he headed the government, his friends carried him home drunk:

"As I struggled to undress him, he stared at me with a curious blank expression. Then, without warning, he

burst into life, shouting and raving like a lunatic obsessed with the madman's craving to smash. He began to break up the apartment furniture, our few pieces of china, even the mirror. Desperately, I woke a neighbor, and we called Dr. Bofandi . . . Between us we tied Benito to the bed, and to my relief, he gradually calmed down.

"On waking the following afternoon, Benito was quite bewildered, refusing to believe my account of what had happened. 'Look,' I shouted, pushing a pile of rubbish toward him, 'You've broken everything. It'll cost a fortune to replace it.' He said nothing, but just stared at the fragments of glass, china and wood. 'Get this into your head,' I said. 'I'll never agree to be married to an alcoholic. When I was little, I had an aunt who drank, and that was enough trouble. I admit you have your good qualities—and I'm even ready to forget about the other women—but if ever you come home again in that state, I'll kill you.' Benito heard me out without saying a word. Then, taking my hand, he led me to the bed where one-year-old Edda lay sleeping. 'I swear to you, on her head, that I'll never do it again' he said.

"I knew he'd keep his promise, because Benito was devoted to his daughter. He would rock her, spend hours watching her sleep and to wake her would sometimes play the violin over her bed. Indeed, apart from the times when he could not avoid sipping a little wine, Benito never again drank alcohol. That memorable night was the start of the Duce's legendary temperance."⁹⁴

She further notes that the Duce had a great deal of respect for the medical profession and, in 1932, enlisted its aid in getting rid of a rice surplus, and in boosting the births of Italian babies to increase future levies of soldiers.⁹⁵ His last mistress, Claretta (Clara) Petacci—who died with him in 1945—was the daughter of a doctor who was the personal physician to Pope Pius XI.⁹⁶ In July, 1943, upon leaving the King's residence after being dismissed as head of the Italian government, Mussolini was arrested and taken away in an ambulance,⁹⁷ and, again, in another one, on Aug. 28th, during his captivity. He hadn't been in an ambulance since his World War I wounding,⁹⁸ his widow relates.

The Cianos: Edda and Galeazzo

Edda, born Sept. 1, 1910, wasn't the Duce's only daughter; a younger daughter, Anna-Maria, had polio.⁹⁹ Like their famous father,

both daughters had rough-and-tumble childhoods. Once, as a girl, Edda cut her head from a fall, and was taken to a doctor for treatment. She recalls:

As soon as stitches were mentioned, my calm attitude abandoned me and I began dashing all over the room seeking escape . . . I fought so wildly that I kicked the doctor in the chin and, in the process of trying to protect himself, he split my brow open a bit more. Instead of *three* stitches, I had to have *six*, and it took the doctor longer to recover from the blows I had given him than it did for me to recover from my injury.¹⁰⁰

On Jan. 27, 1930, at age 19, she met the 27-year-old son of a prominent Italian Navy Admiral.¹⁰¹ She and the young Galeazzo Ciano were married that same year. The Duce's new son-in-law held several important positions in the Fascist regime during his career: as Italian Ambassador to Brazil, Argentina, China and the Vatican in Rome, and, between 1936-43, as Foreign Minister.¹⁰²

A notorious woman-chaser (a fact his widow readily-admits),¹⁰³ Ciano also enjoyed golf for relaxation, ate spaghetti until forced to go on periodic diets¹⁰⁴ and suffered from 1932 from asthma contracted in China until his more violent death 12 years later.¹⁰⁵

The Cianos were divided over Adolf Hitler's becoming Chancellor of Germany in January, 1933—she favoring it, he against.¹⁰⁶ Despite the Duce's later alliance with Hitler, Galeazzo Ciano—mirroring the views of most Italians—was against it, too, favoring the Western powers of Britain and France instead.¹⁰⁷

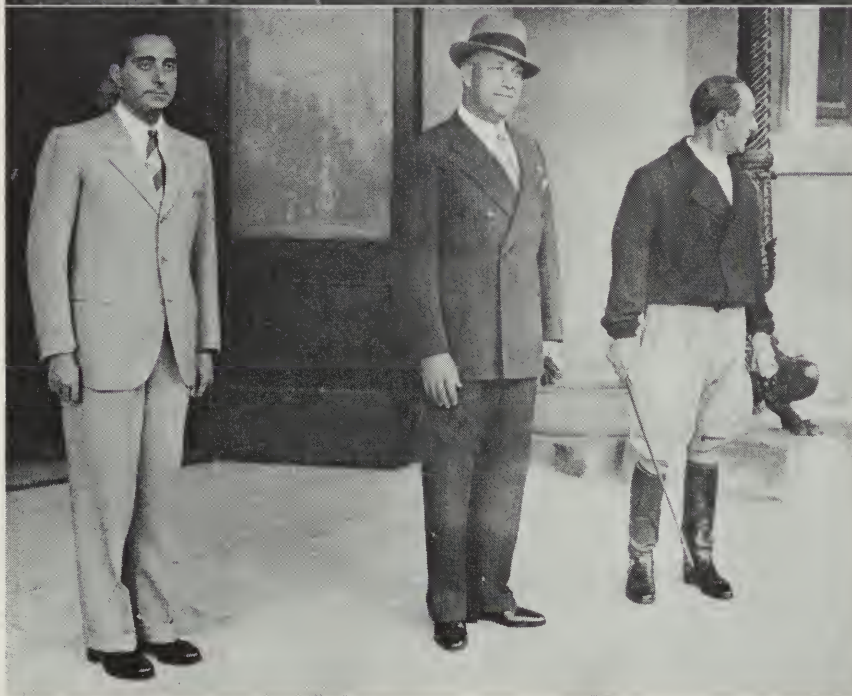
During late July, 1943—though ill with the flu¹⁰⁸—Ciano was one of the members of the Fascist Grand Council who passed a resolution of "no confidence" in the Duce's wartime leadership (which led to Mussolini's dismissal by the King and subsequent arrest). When the Duce was restored to partial power by his German allies, Galeazzo Ciano was arrested, tried for treason and executed by an Italian firing squad in January, 1944¹⁰⁹ (but not before—alá Hermann Goering two years later, at Nüremberg—he tried to take poison secured for him by a doctor. It failed to work, however.)¹¹⁰

Edda escaped to neutral Switzerland, where she began the process of publishing her husband's diaries in two volumes that revealed Galeazzo's opposition to his father-in-law's disastrous German alliance.

Today, Edda (who served as a nurse at Stalingrad in 1942¹¹¹) is 68.

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(Left) **GALEAZZO CIANO**, 1930-38. (Top, left) On his wedding day (with top hat) to Edda Mussolini (not shown) in April, 1930. (Middle) From left to right with Fascist officials Teruzzi and Dino Grandi, and British diplomat Sir John Simon, 1935. (Bottom) Center, in hat, in 1938 with (left) Filippo Anfuso and (right) Achille Starace (whose dead body was hung upside down with the Duce's at a Milan filling station in 1945.

(All pictures from Roma Press.)

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Acknowledgment

The author thanks Mrs. Mildred Chronister for secretarial services. ☐

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House Call

By RAYMOND J. DONOVAN, JR., MD

Dr. Donovan is Chairman of Med-Chi's Public Relations Committee and is affiliated with St. Agnes Hospital, Baltimore, MD.

House Call, the Faculty's very successful television program on general medical topics was seen over WBAL-TV, Channel 11, Baltimore from June 9-Sept. 16, 1977. The inspiration for the series came from a number of sources. Sydney King, WBAL's Public Affairs Director, offered to again use the Faculty in a summer replacement spot following the success of the alcoholism series presented in 1976. At the same time, the Public Relations Committee was in the process of reviewing programs offered for syndication. It was felt a program featuring Maryland physicians could be far more relevant to the community than a packaged program with physicians from other states.

Mr. King was responsible for the title. "We are offering our viewers an electronic house call," he said. A prominent part of every program was answering questions called in

by the viewers. A bank of telephones set up in the studio was ably answered by members of the Faculty's Auxiliary. They recorded viewers' questions and passed them to the physician expert.

I was pleased to act as host for the series, and looked upon the program not only as a public service, but as a chance to meet and exchange information with some of the finest physicians in our medical community. We had no trouble filling the 15 weeks WBAL offered, and could have continued much longer. Viewer response was extremely rewarding, averaging approximately 50 calls per show.

By far the most popular program was **An Overview of Modern Plastic Surgery**. Ronald Cameron, MD, a Bethesda Surgeon, treated the viewers to a series of before-and-after slides, and obviously whetted the interest in both cosmetic and reconstructive surgery.

William J. R. Dunseath, MD, got the program off to an excellent start talking about **Pimple Pickin'—Fact and Fancy**. While getting into some serious dermatological subjects, Bill had a few words for adolescent acne which, judging from the telephone calls, seems to affect an age group of 12-50.

The female physicians of our community were well-represented, beginning with Dr. Lois Young of the University of Maryland Hospital, who spoke particularly to parents on the problem of **Crossed Eyes: A Needless Handicap**. With the use of an intriguing model, she demonstrated some of the problems which occur in young children—particularly those which are correctable. She cautioned, however, that waiting too long for treatment may prevent success. Dr. Sandra Salan, a Howard County physician, gave the viewers a look into **Stroke: Prevention is the Only Cure**. She



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detailed the incidents which can lead to stroke and the viewers re-

sponded by an unusually large number of calls. Dr. Mary Betty

Stevens, of Good Samaritan Hospital, explored **Arthritis Facts and Fancies**. Although she could not speak of cures, she managed to reassure the audience arthritis is a disease with which one can live.

Richard Sarles was not so reassuring in his presentation **The Ups and Downs of Adolescence: How to Survive**. He declared parenting during adolescence the most difficult job in the world, although, somehow, parents and children both seem to manage. Scott Decker presented a less sanguine picture in his treatment of **The Broken Child**. With the use of slides, he detailed the battered-child syndrome and gave viewers much about which to be concerned.

I picked up a few pointers on my TV technique from John Tyson of Johns Hopkins as he joined the show for a discussion of **Risk/Benefits of Hormone Ingestion for Women of Child-Bearing Age**. Among his many careers, it seems John has been on stage most of his life: first, as a part of a performing family, and, during his medical career, as both host and participant on many similar programs. Although he spoiled our record for an all-amateur series, his contribution was indeed appreciated.

The constant ringing of telephones during Anthony Hammond's segment, **Ear, Nose and Throat Problems**, prompted the production staff to comment morning viewers seem much more interested in hearing than in sex. Hammond was aided in his presentation by a beautiful illustration executed by Mrs. Hammond for the program.

Sol Love, a Baltimore City dentist and member of the PR Committee, not only gave excellent pointers on **The Care and Feeding of your Teeth**, but also provided an address where viewers could write and have questions answered. He later reported a good response.

Dr. Joseph McLaughlin brought one of the best heart models to use in his segment on **You and Your Heart**, and viewers responded with enthusiasm to McLaughlin, who serves as Professor and Head of Thoracic and Cardiovascular Surgery at the University of Maryland.



TWO VIEWS OF THE HOUSE CALL SET, showing Drs. Donovan (left) and Phillip Byrd, a physician from St. Agnes Hospital, Baltimore. (Judy Buck photographs.)

Although his catheters and probes seemed pretty frightening at first, Rainer Engel enlightened viewers on **Urinary Tract Infections** without scaring them too much. In fact, extremely thoughtful questions, particularly about infections in young children, were received.

Phillip Byrd, a St. Agnes Hospital Radiologist, brought several films to illustrate the investigatory problems of his specialty. He traced for the viewers occluded vessels and broken bones.

A surprise to all of us was the response to the thoughtful presentation of J. Courtland Robinson, who shared his views on **Rape: A Crime with Health Consequences**. He detailed the progress over the years of handling rape victims, their interaction with the police and the changes in the law enforcement community. Viewers, however, made few calls during the program. Our best estimate was that rape is an interesting topic, but one people find difficult discussing.

We concluded the series with a program which was personally very rewarding. Dr. Theodore Woodward, Chairman of the Department of Medicine at University of Maryland, came to share with us some of his experiences with **Rocky Mountain Spotted Fever**, and infectious disease problems in Baltimore from the past. Dr. Woodward was a teacher of mine, and I knew he would enchant us all with his lively interest in historical medicine. It was a charming note upon which to end the program.

WBAL provided us with excellent assistance, and a most appreciative and helpful crew. Clayton Weaver and Joe Sullivan of the station alternated as program directors. Our floor managers were Henry Silverman and Bill Merryman. Taking an interest in the series, **Medical Economics Magazine** will have a one page feature story on House Call.

The program was a great experience for all of us who participated. Those who missed us each Thursday morning at 10, can see the program on video tape at the Faculty Library, or borrow tapes for home viewing. □



BELLS ARE RINGING, as **MRS. POLLY REITER** (top) and **MRS. GERRY HAMED** (bottom) answer incoming calls to the popular Med-Chi TV show.

(Photos by Judy Buck.)

Doctors in the News

Dr. Hoopes Elected ASPRS Secretary

Dr. John E. Hoopes of Hunt Valley, MD, has been elected Secretary of the American Society of Plastic and Reconstructive Surgeons. He was chosen during the 46th annual convention of ASPRS in San Francisco. Dr. Hoopes, an ASPRS member, is also affiliated with the American Association of Plastic Surgeons, the Plastic Surgery Research Council and the American Society for Aesthetic Plastic Surgery.

He is also certified by the American Board of Plastic Surgery.

Dr. Owens Serves on Bristol-Myers Award Panel

Dr. Albert H. Owens, Jr., Director of the Johns Hopkins Oncology Center in Baltimore (see *Journal* interview, p. 35, September, 1977) recently served as a panel member to determine the winner of the first

annual Bristol-Myers Award for Distinguished Achievement in Cancer Research, which was recently presented to Drs. James and Elizabeth Miller of the University of Wisconsin's McArdle Laboratory for Cancer Research. The panel consisted of five prominent, nationally-known cancer scientists.

Dr. Bianco Elected

Emidio A. Bianco, MD, was recently elected First Vice President of the Board of Trustees of Provident Hospital, Baltimore, by that Board. Dr. Bianco, formerly Director of Medical Affairs and Medical Education at St. Agnes Hospital and currently Director of Medical Affairs for Baltimore City PSRO, also was recently appointed a member of the Criteria Committee of the American Association of PSROs. This Committee will assist the National Council of PSROs to establish screening criteria for selected surgical diagnoses.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefit be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetic mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, tremor, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meal and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complication of Tenuate overdosage.

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A Modern Use for Chloroform?

By JEAN-MAURICE POITRAS, MD, FAAP

Dr. Poitras can be contacted for reprint and other data at 107 Edgerton Rd., Towson, MD 21204.

•
The other day in a little bookshop in upstate New York, I found an interesting book by Arthur Ernest Sansom, MB, London (Late House Physician and Physician's Accoucher's Assistant to King's College Hospital). The book was published in 1865 and entitled '**Chloroform, Its Actions and Administration.**'

I perused the book and was amazed at the knowledge displayed by the physicians of over 100 years ago; however, an item of even greater interest attracted my attention, which I felt deserved the attention of my fellow Maryland physicians as well. It was a newspaper clipping, yellow and frayed with age and falling apart, which a former reader had left ensconced between the pages of this little volume.

The item was a letter to the editor of the **Tribune** dated Jan. 15, 1895. Herewith, is an exact copy of the letter: Is more comment necessary?

CHLOROFORM IN ACCIDENTS: Dr. Wilder Urges That It Be Kept On Hand to Obviate Agonizing Deaths

To the Editor of The **Tribune**:

Sir: In your issue of the 13th under the heading 'Roasted to Death', is described the following accident: On Staten Island Saturday night an explosion caused the wreck and burning of two frame houses. From one there barely escaped a mother and four children. In the ruins of the other was caught a man, who was literally roasted to death before the eyes of hundreds of spectators. Many were made sick; none can ever forget wholly the sight or cease to hear his frantic cries for the help that could not

be given. Rescued he could not have been, perhaps, without tools and mechanism more powerful than were available at short notice in a small place.

But though death was inevitable and came upon him rapidly, its attendant horrors might have been averted. Had there been at hand two ounces of chloroform, a handkerchief, any cloth, or a soft hat could have been saturated with it and pushed under the victim's face. His hands were imprisoned, but a stick, cane or umbrella could have kept the anesthetic in place even after the flames had driven his would-be rescuers away.

But where was the merciful drug? Among all who stood horror-stricken, eager, yet powerless to save, had no one heeded the suggestion offered in the **Tribune** two years ago, soon after the railway wreck at Battle Creek, MI, when a child and a woman were in like manner "roasted to death?" Did no hip pocket contain in place of pistol or whiskey-flask the vial of chloroform? Perhaps each who may have thought of so providing himself took for granted that somebody would do it. Yet none can foresee how soon he may be one of only a few spectators of such a calamity, or even be himself the victim.

Consider the following record. On the dates given were described in the **Tribune** instances in which chloroform might have prevented the bodily suffering of one or more and the scarcely less terrible mental agony of witnesses: In 1882, Jan. 13 at Spuyten Duyvil were burned Sen. Wagner and others; in 1889, May 1, Oct. 17, Nov. 19; in 1890, Jan. 18, March 4; in 1891, July 4, July 28, August 7; in 1892, May 2, Sept. 22, Nov. 11; in 1893, Apr. 21, Aug. 28, Oct. 27, Nov. 20, Nov. 30; in 1894, Jan. 26, Aug. 13, Sept. 11, Sept. 12, Oct. 17; in 1895, Jan. 19.

In commenting on the Battle Creek disaster, I suggested that a metal can of chloroform be carried on every railway car, and that policeman be supplied with it for various purposes, specified and more or less obvious. Why not also all fire-engines, drugstores and liquor-saloons? Of course, all druggists keep it, but not always in a place and available for emergencies. Let the licensed dealer and retailer of spirits require the keeping of chloroform in plain view. In the present case, it is said that one of four who tried to extricate the victim was a "liquor-dealer whose place was close by." In civilized parts of the world, such establishments are seldom far off. Let their proprietors atone for the many woes to which they contribute by furnishing the blessing supremely demanded under certain conditions, euthanasia. So to save another from fiery fortune in this world shall perchance diminish their own commonly-merited similar torments in the other.

Two practical points must be borne in mind. The other familiar anesthetic is ether, and some might naturally substitute it for chloroform. But it is less prompt and highly inflammable so that it would only feed the flames. While the vapor of chloroform is suffocating, anesthetic and,—if carried to excess, as a liquid it is a powerful irritant of the skin and mucous membranes; hence, it should not be permitted to reach the eyes or lips.

This capacity for vigorous irritation of mucous surfaces, however, renders chloroform invaluable for certain other purposes named in my former communication and in a brief note printed on March 2, 1894. Poured upon the nostrils of a fighting dog or other animal it compels him to let go and depart. There have been already several incidents like that described in **The**

Tribune of June 11, 1894, under caption **Bitten by Her Pet Lion**. Allowing for some exaggeration, two things are certain: first, there is real considerable danger in the exhibition of trained lions and tigers; second, when the exhibitor is attacked the immediate effect of clubbing or prodding is to increase the rage of the beast and correspondingly the peril of the man, as is illustrated whenever the same crude methods are directed against fighting dogs. To be effective, therefore, these methods almost surely impair the appearance and disposition of a very costly piece of property, and are by no means easy to employ without injury to the man. If such exhibitions are to continue at all (and their influence and possibilities link them closely to bullfights), then the law, if not the self-interest of the proprietors, should enforce the provision of chloroform in considerable quantities with apparatus for projecting it forcibly as a coarse spray. The man attacked should shut his eyes and a well-trained at-

tendant should be able to avoid him. The advantage of chloroform over ammonia is that it is much safer to handle and its effects are much less likely to cause permanent injury, even to the eyes. It seems to me preferable even in so desperate a circumstance as the following: near Budapest, about Dec. 1, 1894, a party was attacked at night in the forest by wolves and 13 "dragged down and devoured." I verily believe that if travellers in wolf-infested districts were provided with not only firearms, but the means of projecting a stream of chloroform, the fiercest wolves might be kept at bay.

Let me close with the mention of some other cases of chloroform. For more than 20 years, I have at intervals advocated its employment as a lethal agent for condemned animals and criminals and by inexorable suicides. As reported Jan. 5, it was used by the Mayor of Detroit for killing two superannuated horses. At Cornell University are thus disposed of painlessly each year about 400 cats besides many

other creatures. The commendable sentiments that have led to the substitution of the electric chair for the halter in the State of New York should logically prefer chloroform to either. Properly administered, it is one of the sheet-anchors of medicine and surgery. In overdoses and persisted in beyond a certain limit it, of all known agents, destroys life, "tuto, cito jucunde et parvo pretio." Ithaca, NY, Jan. 15, 1895

Burt G. Wilder



Coming in the Journal:

Skilled Orders Get Skilled Care,
by Fred R.T. Nelson, MD and
Lee Elizabeth Britton, MA

Clinical Biofeedback:

Current Status,
by Jesse Rubin, MD

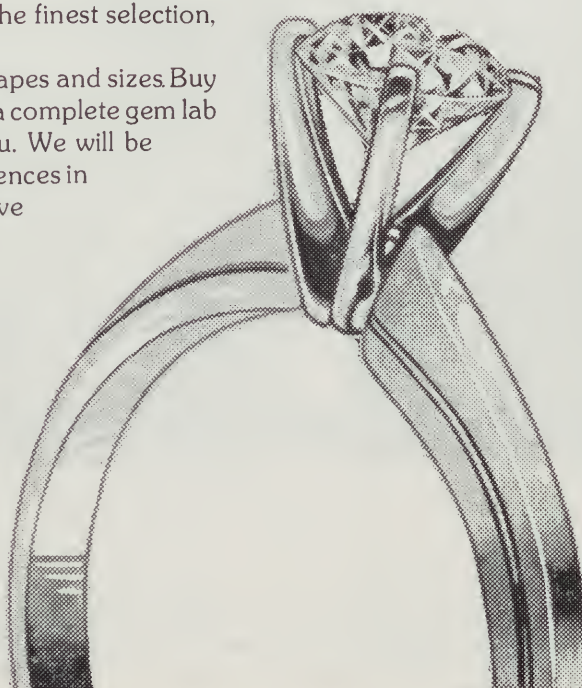
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Doctors in the News

Dr. Borkovich Selected "Internist of the Year"

Dr. Katherine H. Borkovich, a Baltimore physician, was selected "Internist of the Year" by the American Society of Internal Medicine recently. The award was made public at the 22nd Annual Meeting of the Society held in San Francisco.

Dr. Borkovich has many firsts in her distinguished career, having served as the first woman president of the Maryland Society of Internal Medicine and the Baltimore City Medical Society; the first woman staff representative of the Medical Board of the Johns Hopkins Hospital and the first Secretary-Treasurer of the Section on Internal Medicine of the Baltimore City Medical Society. She

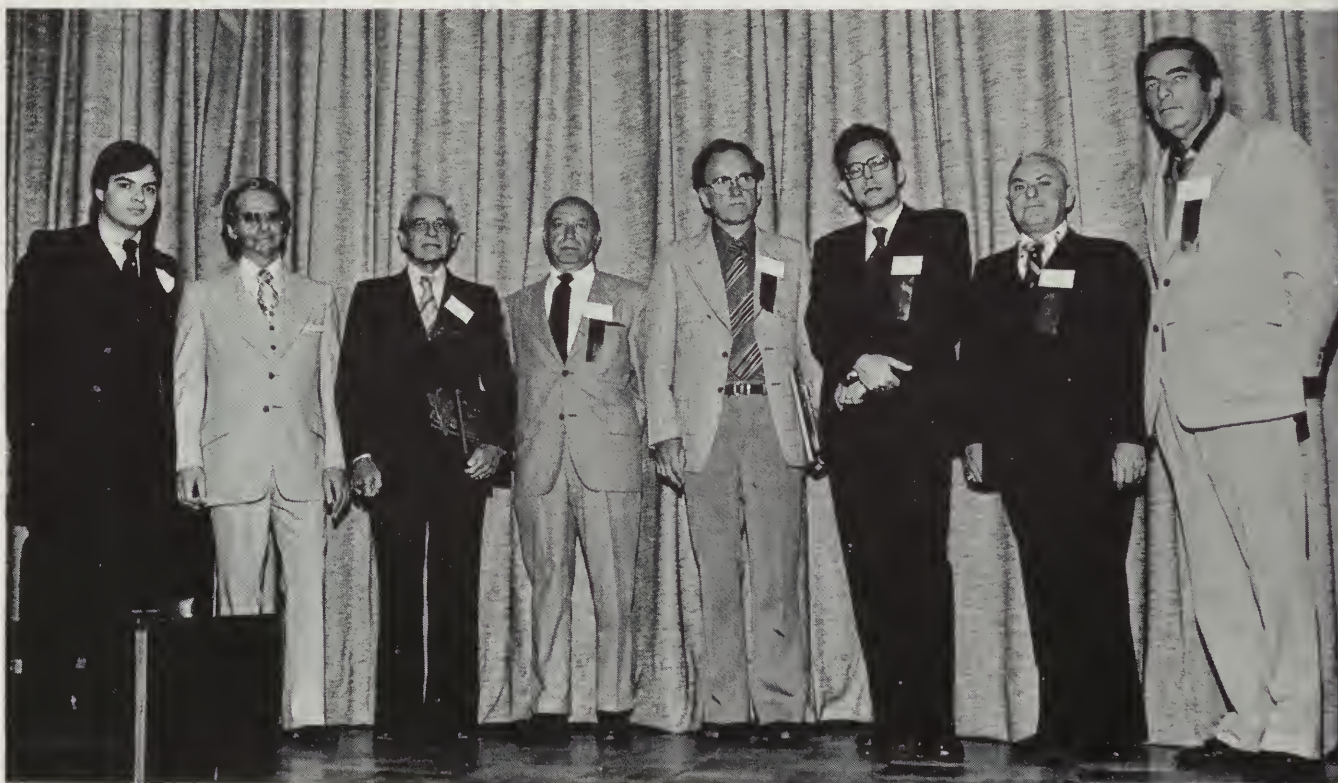
serves on the Council of the Medical and Chirurgical Faculty, has been President of the Johns Hopkins Women's Alumni Association, Member of the Board of Trustees of the Heart Association of Maryland and is a member of the American Medical Association.

Dr. Borkovich was a prime mover in the development of quality of care review mechanisms in Maryland through her efforts in the formation of the state medical society's Peer Review Committee. These activities have been extensively copied in other states throughout the country. She has also worked with the Maryland Blue Shield Utilization Review Committee and with the Baltimore City Professional Standards Review Organization.

Dr. Borkovich, a native of Monaca, PA, is a Board-Certified Internist subspecializing in Cardiology and has practiced and lived in Baltimore since she received her Medical Degree from the Johns Hopkins University School of Medicine in 1939. Her many interests include membership in the Natural History Society of Maryland, the National Audubon Society and the American Forestry Association, the Sierra Club, the Adirondack Mountain Club, the fishing Club of America and the National Travel Club.

Coming in the Journal:

Carcinoma Arising in a Villous Adenoma in a 19-Year-Old Male With Review of the Literature, by Atef Al-Sibai, MD; Victor Albites, MD; Konstantinos Dritsas, MD, FACS and Neil Novin, MD, FACS



THE 10TH ANNUAL SYMPOSIUM SPONSORED BY TAYLOR MANOR HOSPITAL at Ellicott City, MD was highlighted by the appearance of National and International Leaders in the field of psychiatry who participated in the program **Mood Disorders: The World's Major Public Health Problem**. From left to right Dr. **Davd Behar**, University of Iowa, winner of the student paper award; **Irving J. Taylor**, MD, Medical Director, Taylor Manor Hospital; **Heinz E. Lehmann**, MD, winner of the Psychiatric Symposium Award, a conference speaker; **Jack Weinberg**, MD, President of the American Psychiatric Association and a conference speaker, **Mogens Schou**, MD, winner o the Psychiatric Symposium Award and speaker; **Norman Sartorius**, MD, Director, Division of Mental Health, World Health Organization and speaker; **Frank J. Ayd, Jr.**, MD, Director of Professional Education and Research at Taylor Manor Hospital and speaker and **Bertram Brown**, MD, Panel Moderator and Director of the National Institute of Mental Health.

Neurologic Complication of Massive Doses of Penicillin G in the Obstetric-Gynecologic Patient

By H. MELVIN RADMAN, MD

For reprint and other data, contact Dr. Radman at 3601 Clarks Lane, Balto., MD 21215.

The availability of and the reputed safety of the newer types of penicillin has fostered the intravenous use of massive dosage in some type of obstetric and gynecologic patients. The spectre of complications associated with septic abortion, infected postpartum patient or in those who have had a tubo-ovarian abscess or who become infected after a gynecologic operation has been responsible for the administration of large doses of antibiotics by the intravenous route. However, attention must be directed to the possibility that complications from the treatment may prove to be equally as hazardous as the original disease.¹⁻³

Johnson and Walker in 1945¹ were among the first to demonstrate some of the untoward neurologic reactions to penicillin when that drug was given intrathecally for the treatment of meningitis. More recently, Weinstein et al.² in a study of the effect of large doses of penicillin G in infection, concluded that serious hazards may be encountered when they are used intravenously. Those reactions are central nervous system irritation and hyperkalemia. Where there is decreased kidney secretion that stems from infection, the possibility of the development of epileptiform seizures must be considered because of the resultant high spinal fluid level. Under such conditions the half life of the antibiotic is prolonged, and the quantity of the drug must be drastically reduced.

The importance of the control of infection in the obstetric-gynecologic patient has been emphasized since the time of Semmelweis, Holmes and Lister and most recently by Ledger.⁴ The discovery of antibiotics has proved to be a boon to the parturient woman as well as those with pelvic infection. When urinary suppression accompanies the septic process, the judicious use of penicillin becomes a necessity and a paramount issue in the recovery of the patient.

Although these facts are comparatively well-known in the surgical and medical fields, their relationship to the infected obstetric-gynecologic patient has not been emphasized. It, therefore, becomes important to record some of the details in the case report that follows.

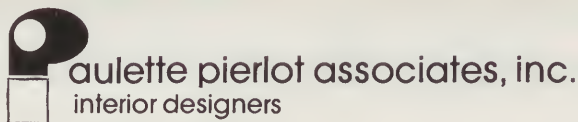
Case Report: Miss C. B., age 18, para 0, entered the hospital for a therapeutic abortion for sociopsychic reasons. Because of the irregularity of her periods and equivocal physical and laboratory findings, it was difficult at first to establish her pregnancy. However, a serum pregnancy test three weeks prior to hospital admittance was positive. Her general somatic status was good. Under general anesthesia, the uterus was evacuated by both aspiration and curettage. Approximately 48 hours after discharge from the hospital, she had

chills, elevation of temperature and abdominal pain. When seen two days later, she had a fever of 101° F and pulse rate of 100. Although she did not appear to be gravely-ill, she was in moderate discomfort. The somatic status was good and the positive findings were limited to the lower abdomen and pelvis. The uterus was enlarged to about three cm. below the umbilicus. There was marked tenderness and some spasm over the whole lower abdomen. On pelvic examination, the cervix was open and exuded a purulent exudate.

The uterus was enlarged and tender, as previously described. A uterine and cervical culture subsequently proved to be negative for *Bacillus Welchii*. Intravenous fluids were started to which were added three units of oxytocin. In addition, 10 million units of penicillin G were given intravenously every six hours. By mid-afternoon, six hours after admittance, she expelled macerated and foul-smelling elements of the products of conception. The temperature which had risen to 104° F now fell to within normal limits. Vaginal bleeding became very active and the inability of the blood to clot was noted. Blood pressure fell and she was in borderline shock. Because of the hemorrhage and clot deficiency, two units of whole blood and one unit of fibrinogen were given.

Evidence of hypofibrinogenemia continued and because of concern in regard to intravascular clotting, 75 mg. of Heparin was given. The continued bleeding precipitated the necessity of further uterine exploration and, consequently, 12 hours after hospitalization, a curettage was done under general anesthesia. Central venous pressures were initiated to monitor her condition and two additional units of blood were given. At this point, the clotting deficiency had been corrected. While the initial urinary output was satisfactory, she became oliguric six hours after first observation, excreting two-four cc. of urine per hour. There was no improvement despite the administration of Mannitol and Ethacrynic acid. The patient became increasingly edematous and both blood urea and creatinine began to rise, although the potassium remained within normal limits. Fluid intake was limited, reverse isolation was established, but intensive intravenous penicillin was continued. Within 24 hours, she had a severe convulsion which was controlled by Dilantin and phenobarbital. Peritoneal dialysis was done with marked improvement in the edema, a diminution of the urea and creatinine levels, but with no effect upon the oliguria.

The intravenous penicillin had been reduced so that she received 1/3 of the original dose. Peritoneal dialysis was repeated in one week because of continued oliguria and edema and another rise in the blood urea and



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creatinine. However, in the third week she began to diurese copiously. The secondary anemia was treated with one unit of packed cells and oral preparation of iron. In the fourth week, she was entirely well with no edema, no evidence of urinary tract infection, the pelvic disease under control, improvement in the secondary anemia and return of the blood urea and creatinine to normal levels. At the end of this week, she was discharged from the hospital as well.

Discussion

Since Johnson and Walker in 1945 demonstrated the dangers of large doses of intrathecally-administered penicillin G, several investigators have substantiated their observations. The obstetric patients who have had a septic abortion or a severe postpartum infection are prime candidates for massive doses of intravenous penicillin. This is also true of women who have become infected following gynecologic procedure or who have had a ruptured tubo-ovarian abscess. Generally this type of treatment is effective in controlling the disease, along with other supportive measures. Should urinary suppression become a complication, a judicious appraisal of the therapy must be made in order to avoid central nervous system sequelae. The case report is presented to emphasize the fact that although known in other fields of medicine, the neurotoxic effects of large doses of intravenous penicillin G when given to patients with oliguria may be dangerous.

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Variable Resistance of Shigellae to Ampicillin Within a Single Community

By ELLEN R. WALD, MD; ARNOLD WALD, MD; PATRICIA CHARACHE, MD and RAY R. ARTHURS, BS

Dr. Ellen Wald is Assistant Professor of the Departments of Pediatrics and Medicine at the University of Maryland Hospital; Dr. Arnold Wald is Assistant Professor in the Department of Medicine at Baltimore City Hospitals; Dr. Charache is Associate Professor in the Departments of Laboratory Medicine and Medicine at the Johns Hopkins Hospital and Mr. Arthur is Assistant Laboratory Manager of the Department of Laboratory Medicine at Johns Hopkins Hospital. Address reprint requests to the Dept. of Pediatrics, University of Maryland Hosp., 22 So. Greene St., Balto., MD 21201.

Introduction

A review of Shigellae isolations in three major hospitals in Baltimore reveals important intracity differences in susceptibility to ampicillin. Susceptibility tests were performed either by the agar dilution method or by the Kirby-Bauer technique; 23 strains were assessed by both methods with agreement in susceptibility designation. In Baltimore, the overall mean rate of resistance of Shigellae to ampicillin was 40% with a range from 6% to 53%.

Emerging antimicrobial resistance of Shigellae isolates has resulted in frequent changes in therapeutic recommendations. An awareness of current resistance patterns is important as a guide to appropriate initial therapy in those cases where antimicrobials are indicated. The efficacy of appropriate antibiotic therapy in shigellosis has been repeatedly demonstrated¹ and is only deferred in those cases where the risk of toxicity of the treatment regimen exceeds the risk of the untreated disease.²

An increasing number of multiple drug-resistant Shigellae isolates have been reported from a number of geographic areas within the United States, including Washington, DC,³ Kansas,⁴ Connecticut,⁵ New York,⁶ Texas,⁷ Michigan⁸ and Georgia.⁹ Baltimore's proximity to Washington, DC, where 95% of isolates of Shigellae were reported resistant to ampicillin in 1971, prompted us to review the resistance patterns of Shigellae in Baltimore.

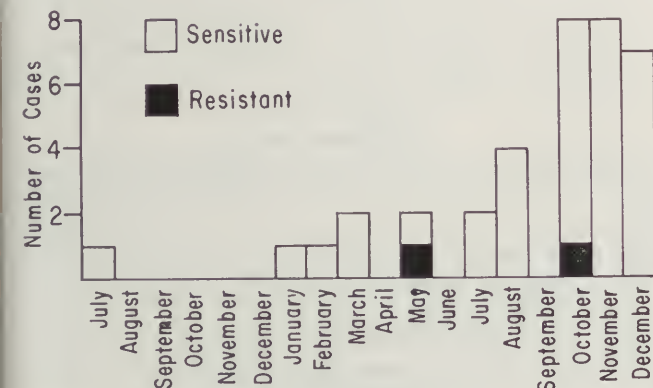


FIGURE 1: Number of isolates of S. Sonnei by month at UMH.

Materials and Methods

All the strains of Shigellae in this study were isolated from infants, children or adults who were outpatients at the University of Maryland Hospital (UMH), Baltimore City Hospitals (BCH) or the Johns Hopkins Hospital (JHH) during the period July, 1974 through December, 1975. These organisms were confirmed to be Shigellae by the Maryland State Health Department Laboratory and consisted of 126 isolates of *S. sonnei*, 1 *S. dysenteriae* and 16 *S. flexneri*. Susceptibility tests were performed by the Kirby-Bauer technique (UMH and BCH), by agar dilution technique (JHH) or by both methods. In the Kirby-Bauer technique, the isolate was plated on Mueller-Hinton agar and high content antibiotic discs were employed. Interpretation was on the basis of the size of the zone of inhibition. Sensitivities to ampicillin (10 mg.), carbenicillin (50 mg.), cephaloridine (30 mg.), chloramphenicol (30 mg.), kanamycin sulfate (30 mg.), tetracycline (30 mg.), dihydrostreptomycin sulfate (10 mg.) and colistin sulfate (10 mg.) were determined.

The agar dilution method used is the reference standard method,¹⁰ using a Steers replicator, Mueller-Hinton agar at 4 mm. depth of medium and 104 organisms per inoculum site.

Results

One hundred and forty-three strains of Shigellae obtained from three large medical centers in Baltimore were compared with respect to susceptibility to ampicillin. Resistance to ampicillin was not observed in the single isolate of *S. dysenteriae* or in the 16 *S. flexneri*. When the three institutions are observed individually, the rate and pattern of resistance among *S. sonnei* strains have been shown in the figure from UMH, BCH and JHH. At UMH, 6% of strains were resistant; at BCH, 43% were resistant and at JHH, 53% were resistant to ampicillin. When all the *S. sonnei* isolates are taken together, the rate of resistance was 40%. The

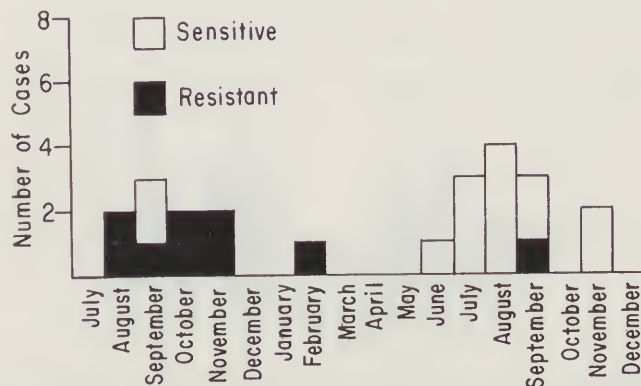


FIGURE 2: Number of isoates of S. Sonnei by month at BCH.

susceptibility of 23 strains (obtained from UMH and BCH) of *S. sonnei* to ampicillin were assessed by both Kirby-Bauer and agar dilution methods; there was agreement in susceptibility designation for each isolate.

Discussion

Reports of Shigellae that are multiply drug-resistant have come from many institutions in the US,^{3-5,8-9} as well as abroad.¹¹⁻¹² However, reports of local differences in antibiotic resistance patterns within a region or city have been infrequent. A report from Michigan,⁸ which represented the accumulation of Shigellae isolates from 30 different counties, noted increased antibiotic resistance from the most urban part of the state. Neu et

al⁶ examining Shigellae isolates from New York City found ampicillin resistance rates to vary between 25-67% as determined by the geographic location of the municipal hospital. All other reports represent an experience at a particular hospital or institution. It is important to recognize that the experience of one institution may not be an accurate reflection of the pattern in the surrounding community.

Summary

An examination of the patterns of Shigellae resistance over an 18-month period in Baltimore revealed impressive differences at the three major inner city hospitals. Although the overall mean rate of ampicillin resistance of Shigellae was 40%, the incidence of resistance ranged from a low of 6% at the UMH to a high of 53% at JHH. An awareness of highly-localized difference is necessary as a guide to appropriate initial therapy in those cases where antimicrobial therapy is indicated.

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Acknowledgment

The authors are grateful to Marvin Cornblath, MD for review of the manuscript and to Ms. Linda Gilbert for secretarial assistance.

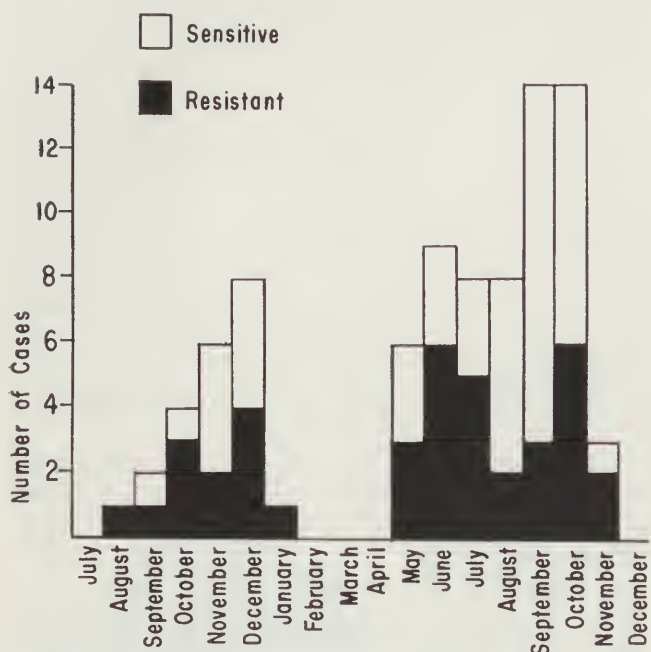


FIGURE 3: Number of isolates of *S. Sonnei* by month at JHH.

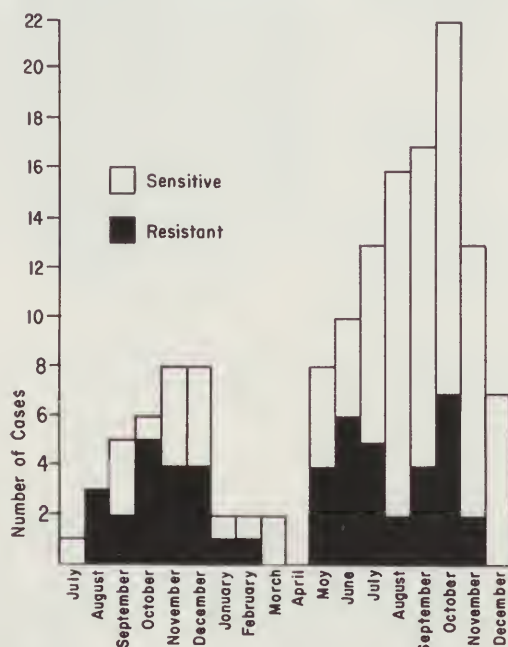


FIGURE 4: Number of isolates of *S. Sonnei* at UMH, BCH and JHH.

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THEME: RECENT ADVANCES IN MEDICINE AND THEIR APPLICATION TO DAILY PRACTICE

Among the Maryland specialty societies preparing presentations for the Annual Meeting are:

WEDNESDAY, MAY 2

Maryland Society of Allergy
Maryland Ophthalmological Society
American College of Surgeons, Maryland Chapter
Maryland Orthopedic Society
Negotiations Seminar for Hospital-Affiliated Physicians
Maryland Radiological Society

THURSDAY, MAY 3

Maryland Dermatological Society
Maryland Urological Society
Maryland Society of Cardiology
Maryland Psychiatric Society
Committee on Alcoholism, Med-Chi
Committee on Occupational Health, Med-Chi, Maryland Industrial Med. Assn.
John Staige Davis Society of Plastic Surgeons of Maryland
Plenary Session—Prospective Medicine
Seminar on Antibiotics

FRIDAY, MAY 4

Maryland Society of Nuclear Medicine
American Diabetes Association, Maryland Affiliate, Inc.
American Heart Association, Maryland Affiliate, Inc.
American Academy of Pediatrics, Maryland Chapter
Maryland-D.C. Society of Anesthesiologists
Maryland Society of Otolaryngology
American College of Emergency Physicians
Maryland Society of Pathologists
Coggins Lecture on Geriatrics
Kress Lecture on Rheumatology and Pulmonary Disease
Obstetrical and Gynecological Society of Maryland
Joint Seminar by Physician Rehabilitation and Peer Review Committees, Med-Chi and Commission on Medical Discipline, State of Maryland
Maryland Society of Rehabilitation Medicine
Seminar on Medical Records

Above scheduling is subject to change. Please check Advance Program and Final Program for an update on scheduling, topics and speakers.

In addition to the scientific program, Annual Meeting highlights will include:

- | | | |
|-------------------------------------|--------------------------|---------------------------|
| *HOUSE OF DELEGATES MEETINGS | *HEALTH EVALUATION TESTS | *HOSPITALITY NIGHT |
| *LUNCH AND LEARN SESSION | *AUXILIARY FUNCTIONS | *SCIENTIFIC AND TECHNICAL |
| *MEET THE SPEAKER | *MMPAC LUNCHEON | EXHIBITS |
| *PRESIDENTIAL RECEPTION AND BANQUET | *PRAYER BREAKFAST | *EXHIBITORS' SWEEPSTAKES |

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181st Annual Meeting
MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
MAY 2-4, 1979
HUNT VALLEY INN, HUNT VALLEY, MD

SCIENTIFIC EXHIBIT APPLICATION

Scientific exhibits are an integral part of the Annual Meeting. All physicians, medical institutions and organizations having an appropriate exhibit are urged to complete the application below for consideration by the Exhibit Subcommittee.

PLEASE INDICATE THE CATEGORY OF EXHIBIT:

- ☐ **SCIENTIFIC EXHIBIT:** Result of original scientific research which involved the personal contribution of the exhibitor. Its purpose is to advance medical knowledge. It should not be designed for the personal, financial gain of the exhibitor.
EXHIBIT FEE: Waived.

- ☐ **CLINICAL DISPLAY EXHIBIT:** Must be of a scientific nature, but not necessarily original research. The exhibitor need not be personally involved in the research. The exhibit should contribute to the advancement of knowledge of other members of the profession, but it may also contribute to the personal, financial gain of the exhibitor.

EXHIBIT FEE: \$150 for each 6' by 10' space.

- ☐ **EDUCATIONAL:** Any exhibit of a scientific and non-commercial nature which does not fit into either of the above two categories. Included would be voluntary health organizations and local and State agencies.

EXHIBIT FEE: \$60 for each 6' by 10' space.

PLEASE COMPLETE AND SUBMIT BY JAN. 31, 1979

Chairman, Subcommittee on Exhibits
Med-Chi
1211 Cathedral St.
Baltimore, MD 21201

DATE SUBMITTED

TITLE OF EXHIBIT

NAME AND PROFESSIONAL TITLE OF EXHIBITOR

EXHIBITOR'S ADDRESS TELEPHONE

CITY STATE ZIP

INSTITUTION PARTICIPATING IN EXHIBIT

AMOUNT OF SPACE REQUIRED WIDTH DEPTH HEIGHT

ELECTRICAL REQUIREMENTS

ANY SPECIAL REQUIREMENTS NOT COVERED IN THIS FORM

HAS EXHIBIT BEEN SHOWN AT OTHER MEDICAL MEETINGS?

PLEASE ATTACH A 50-WORD DESCRIPTION OF EXHIBIT.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide a back-drop and side rails for the booth, 500-watt electric current outlet, one covered table and two chairs.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY

DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed ONE inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

Medical Annals of Maryland, 1899-1925

Edited by

L. H. MILES, Managing Editor

Maryland State Medical Journal
1971-74

Pre-1932 Surgery

By ALEXIUS McGLANNAN, MD

Editor's Note: Born at Baltimore on July 24, 1872, Dr. McGlannan received his MD from the University of Maryland in 1895. He served as President of the Medical and Chirurgical Faculty in 1929. A specialist in Surgery, he had offices at 115 West Franklin Street, Baltimore, when this article was written in 1932. He died at Baltimore February 25, 1940.

Early Developments

Up to 1925 surgery was marked by development of the surgical specialties. Laryngology, Neurosurgery, Orthopedics, Urology, and other branches have grown and expanded to a remarkable degree.

Modern surgery has progressed on the principles of asepsis and anesthesia. Present-day aseptic technique, in large measure, developed in Baltimore under the leadership of Dr. W.S. Halsted. The use of the rubber glove, originally devised to protect the sensitive skin of the operating room nurse, was extended to the assistants and then to the surgeon to overcome the necessarily imperfect disinfection of living skin. The short sleeves of the sterile operating gown were lengthened so that the cuff was covered by the glove. A face mask was added to limit the probability of droplet infection from the mouth. And in the earlier years of the century, when hirsute adornment was more or less the mark of the surgeon, a special sterile covering encased the beard.

Suits made of washable material, usually white, replaced the street clothing or the morning or evening dress affected by the surgeons of pre-antiseptic days, and a washable cap or other form of head gear covered the scalp of all taking part in the operation.

Today such is the armor of the surgeon all over the world, and the picture of an operating room in action shows slight variations whether the scene is in the Congo or in Maryland.

Anesthesia

The debate on the relative merits and dangers of ether and chloroform was still in progress in 1900. The disadvantages of both led to the adoption of nitrous oxide-oxygen and ethylene oxygen as substitutes or adjuvants to the older agents. Later, tribromethanol (avertin) and various barbital compounds were introduced, but, at the present time, the use of these drugs is limited to their employment preliminary to the administration of some other anesthetic.

The search for a safe and pleasant method of an-

esthesia stimulated the study of local analgesic agents. Halsted was a pioneer in this investigation. He developed infiltration anesthesia to a wide degree and created conduction anesthesia, infiltrating and bathing the nerve fibers with cocaine and similar drugs. In 1922, the National Dental Association presented Dr. Halsted with a gold medal, "in recognition of his original researches and discoveries upon which the technique of local and neuroregional anesthesia in oral and dental practice now rests."

Dr. Harvey Cushing and Dr. James F. Mitchell, pupils of Dr. Halsted, did much to spread the knowledge and practice of local anesthesia.

Abdominal Surgery—Penetrating Wounds

Immediate intervention in abdominal catastrophes was not universally agreed upon as the best practice in 1900. Dr. Randolph Winslow reported a series of cases of gunshot wounds of the intestine, treated by immediate operation. Discussing this paper, Dr. W.B. Coley said: "This is the highest percentage of recoveries with which we are familiar."

Perforation of Intestine

Cushing advocated prompt operation under infiltration anesthesia in cases of perforation of typhoid ulcers. He made a distinction between the progress of the peritonitis in cases of slow perforation of the appendix where adhesions limit the process and those of the ileum where the anatomical relations are less favorable.

Appendicitis

The literature of the early years of the century is rich in references to appendicitis. Kelly and Hurdon's book on the appendix and its diseases is one of the most valuable contributions to this important subject.

Stomach

Pyloroplasty, as devised by Dr. J.M.T. Finney, is a valuable method for dealing with peptic ulcer and benign pyloric obstruction. By means of this operation, the obstruction is relieved without disturbance of the physiology of digestion. Hughson's experiments on the effect of vagus neurotomy on the pyloric sphincter are important in the study of diseases of the digestive organs.

Cushing published a method for sterilizing the contents of the stomach by disinfecting the mouth and the use of sterile food preliminary to operations on the upper gastrointestinal tract.

Biliary Tract

Halsted was the first American to operate on the common bile duct and made many contributions to the surgery of the biliary tract. His last one was the drainage of the common duct by means of a tube passed through the cystic duct.

Pancreatitis

Dr. Eugene Opie showed the relation between biliary obstruction and acute hemorrhagic pancreatitis.

Resection of the Pancreas

Finney and Finney, Jr. successfully resected the pancreas for the relief of hyperinsulinism.

Peritoneal Vaccines

The development of vaccines against peritonitis had its onset, in part at least, in Halsted's experiments in which he inoculated the peritoneal cavity of animals with pure cultures of staphylococcus aureus. The experiments proved that the presence of a foreign body in addition to the bacteria is necessary for the development of peritonitis.

Hernia

The probability of curing inguinal hernia by surgical operation is shown in Bloodgood's report on Halsted's operation. This report is of great interest, not only because it was the most careful report on the radical cure of hernia published at that time, but also because it was the first paper to record the value of rubber gloves in aseptic technique. Bloodgood, beginning in 1896, was the first operator to wear rubber gloves as routine practice in all clean operations.

In later development of the hernia operation, Halsted brought out the method of utilizing the cremaster muscle and the rectus sheath for the cure of the more difficult forms of this lesion. McArthur made use of strips of the aponeurosis of the external oblique muscle and later Gallie transplanted strips from the fascia lata in order to close hernial openings with living tissue. Dr. Amos Kuntz has had success using preserved animal fascia for the same type of operation.

Dr. Randolph Winslow successfully closed an ectrophy of the bladder in a female child. Nearly 30 years later he was able to report on her condition. She had just been delivered of her fourth child, and was a well-nourished, healthy woman, able to perform her household duties in a satisfactory way.

Intestinal Obstruction

The search for the lethal agent in acute intestinal obstruction has led to many interesting experiments. Whipple, Stone and Berheim, working with dogs, showed that the material which accumulated in closed duodenal loops, when injected into other healthy dogs, caused their death.

Blood Vessels

Halsted performed the first successful ligation of the first portion of the left subclavian artery, and also the first excision of a subclavian aneurysm. "His best paper seems to be that on the Ligation of the Left Subclavian Artery," McCallum stated. His interest in the surgery of the large vessels led to the development of his metal bands for the partial occlusion of an artery for the cure of aneurysm. By experiment, he determined the cause of aneurysm of the subclavian artery associated with cervical rib.

Dr. Dean Lewis studied the collateral circulation of the lower extremity in cases of thrombo-angiitis obliterans, adding to the knowledge of the course of this disease as well as to the methods for its treatment.

Ductless Glands

Halsted's early experimental work on the thyroid is reflected in his monograph, *The Operative Story of Goitre*, published in 1920. In the course of his work, he brought out the relation of the thymus and thyroid in certain cases, and the possibility of transplanting the parathyroid glands for the prevention of tetany. He demonstrated that a parathyroid transplant one quarter of a millimeter in diameter maintained a dog in good health. He also proved that a deficiency must exist in order that the transplantation of these glands be successful.

Dr. Harvey Cushing's experiments and discoveries relating to the pituitary gland will be discussed elsewhere in this volume.

Suprarenal

The relation of tumors of the suprarenal to hypertension is of great interest; this interest is intensified by the report of a tumor of the medulla of the suprarenal successfully removed by Shipley.

Malignant Tumors

The American Society for the Control of Cancer was organized in 1913 for the purpose of bringing to public attention the dangers of tumors in the hope that education would lead those afflicted with malignant tumors to seek relief at a time when there is greater probability of cure. Most of the statistics on which the original propaganda of the society was based came from the laboratories of surgical and gynecological pathology under the direction of Drs. Bloodgood and Cullen.

Cancer of the Breast

Halsted's original contribution to this subject, practically contemporaneous with that of Willy Meyer of New York, was followed by a series of reports in which the results were carefully recorded. Gradually, the operation was taken up by other surgeons; and at this time, it is in universal use. Many modifications have been devised, but the underlying principle remains. Dr. Halsted made few changes in the details of the operation. The extent of skin removed was increased rather than diminished, and the dissection of the neck was abandoned as a routine practice.

Bone Tumors

In the early days of the Roentgen ray, Baetjer and Bloodgood studied the bone specimens in the laboratory of Surgical Pathology of the Johns Hopkins Hospital by this means of investigation, and correlated their findings with the clinical history of the patient and the pathological characteristics of the bone tumors. This study proved that operation in cases of bone tumors should vary according to the character of the tumor, that amputation is not always necessary, and that exarticulation at the highest joint is only indicated in the most malignant forms of sarcoma, or in other less malignant sarcomata on account of their position near the joint or their infiltration of soft parts.

The recent publication of Geschickter and Copeland is a valuable contribution to our knowledge of bone tumors.

Roentgen Ray

The medical profession was prompt in recognizing the usefulness of Roentgen's discovery. Soon after his announcement of the properties of the X-ray, in December, 1895, Roentgen laboratories were established and became an indispensable part of active hospitals. Such laboratories were opened in Baltimore without delay, one of the first being that of Dr. Christian Deetjen.

In one of the early reports on the use of the X-ray in clinical surgery, we find Dr. Louis McLane Tiffany's report of a chisel imbedded in the nasopharynx. The position and character of the foreign body were recognized by means of the X-ray examination and Dr. Tiffany, by an ingenious operation, was able to remove the chisel. The patient made an uneventful recovery.

With the establishment of Roentgen laboratories, a new specialty began to emerge and the skillful skiagraphers of 1900 have developed into the Roentgenologists of today.

Plastic Surgery, Skin Grafting

Plastic surgery has developed into a special field of surgery.

Skin grafting remains of interest and importance to the general surgeon. Dr. John Staige Davis invented the small deep graft more popularly known as the pinch graft, a most useful method of skin grafting.

Teaching

Teaching is a prominent characteristic of Maryland surgeons. From the time of Davidge, who is responsible for the organization of the Medical College of Maryland, the forerunner of the University of Maryland, the fifth medical school in the United States, surgeons have taken an important part in the development of medical education.

At the turn of the 20th Century, the professors and associate professors of Surgery in Baltimore were these doctors:

C.F. Bevan, College of Physicians & Surgeons; J.D. Blake, Baltimore Medical College; Jos. O. Branham, Maryland Medical College; J.W. Chambers, College of Physicians and Surgeons; J.M.T. Finney, Johns Hop-

kins University; W.S. Halsted, Johns Hopkins University; A.C. Harrison, College of Physicians & Surgeons; Frank Martin, University of Maryland; L.M. Tiffany, University of Maryland; I.R. Trimble, College of Physicians and Surgeons; R.B. Warfield, Baltimore Medical College; and Randolph Winslow, University of Maryland.

The most prominent member of this group is Dr. Halsted. The extent of his contributions is indicated by the references to his work in this review. He developed a new school of surgeons; his influence on the practice of surgery has been carried to all parts of the world by his pupils and remains an inspiration for those who practiced in Baltimore during his lifetime. Dr. Halsted died Sept. 27, 1922.

The professorship of Surgery in the Johns Hopkins is a full-time position. Dr. J.M.T. Finney successfully carried on the work as chief of the surgical department until a successor for Dr. Halsted was found in Dr. Dean Lewis, who came to Baltimore from Chicago in 1925.

As a result of mergers, the number of medical schools in Baltimore has been reduced to two: the schools of the University of Maryland and the Johns Hopkins University.

The professors and associate professors of Surgery in 1932 are these MDs:

J.C. Bloodgood, Johns Hopkins University; J.S. Davis, Johns Hopkins University; C.R. Edwards, University of Maryland; J.M.T. Finney, Johns Hopkins University; W.M. Frior, Johns Hopkins University; R.H. Follis, Johns Hopkins University; E.H. Hutchins, University of Maryland; F.L. Jennings, University of Maryland; Dean D. Lewis, Johns Hopkins University; F. Lynn, University of Maryland; Alexius McGlannan, University of Maryland; A.M. Shipley, University of Maryland; H.B. Stone, Johns Hopkins University; and W.D. Wise, University of Maryland.

American College of Surgeons

The American College of Surgeons was organized in 1913 to elevate the standards of Surgery in America. The initial success of this organization was due in no small part to the confidence of the surgeons of the United States in the wisdom and integrity of the first President, Dr. J.M.T. Finney of Baltimore.

The Maryland Surgeons enrolled at the first convocation of the College were:

T.A. Ashby, W.S. Baer, B.B. Bernheim, J.C. Bloodgood, J.W. Chambers, C.A. Clapp, S.M. Cone, T.S. Cullen, J.S. Davis, S.G. Davis, Jr., S.T. Earle, J.M.T. Finney, W.A. Fisher, R.H. Follis, Harry Friedenwald, A.C. Harrison, J.M. Hundley, G.L. Hunner, H.A. Kelly, Frank Martin, Alexius McGlannan, W.E. Moseley, O.B. Pancoast, W.B. Platt, A.J.N. Reik, H.O. Reik, W.W. Russell, A.M. Shipley, George Walker, J.W. Williams, J.R. Winslow, Randolph Winslow, T.C. Worthington, and H.H. Young.

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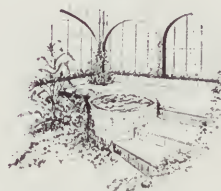
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Medical Miscellany

Schweiker-Kennedy Bill

Congress in its closing hours in October, 1978, gave its final approval to the Health Maintenance Organization Act Amendments of 1978 sponsored by US Senators Richard S. Schweiker (R-PA) and Edward M. Kennedy (D-MA.)

"The success of this important health legislation is the result of bipartisan cooperation involving the Carter Administration and many members of the Senate. This effort reflects the view that Health Maintenance Organizations can become a major asset in holding down health costs and meeting national health care goals," Schweiker said.

HMOs are pre-paid health plans in which members make fixed regular payments entitling them to a variety of health care services. The emphasis in HMOs is on preventive care, rather than the treat-

ment of chronic or crisis illness. Because of prepayments, there is an economic incentive to maintain HMO members' health to avoid costly or unnecessary treatment.

Schweiker pointed out that HMOs are a promising way for driving down health care costs and, at the same time, improving access and quality of care through the operation of internal incentives, rather than direct government regulation.

The major provisions of the bill are:

Strengthens provisions designed to prevent fraud and abuse in the HMO program.

Extends for three years the authorizations of appropriations for HMO feasibility, planning and initial development grants and contracts for a three-year total of \$164 million.

Adds new authority for loans and loan guarantees to assist in the costs of equipping, constructing, acquiring or renovating ambulatory care facilities. This could mean up to \$2.5 million per HMO facility.

Extends for three years the au-

thority for initial operating loans and loan guarantees. The maximum was raised from \$2.5 to \$4.5 million per HMO.

Authority to train HMO managers and provide HEW technical assistance.

Sen. Schweiker is ranking Republican on the Senate Health Subcommittee, while Sen. Kennedy is the Chairman. □

Donovan-Corman Debate

National Health Insurance for the United States was the subject of a debate before the Pennsylvania Political Union of the University of Pennsylvania between Representative James C. Corman (D-CA) and **Raymond J. Donovan, Jr., MD**, a Baltimore surgeon and member of the *Journal's* Editorial Board.

Dr. Donovan, whose practice is centered at St. Agnes Hospital, is Chairman of the Med-Chi Public Relations Committee and a member of the Speakers' Bureau of the American Medical Association.

Rep. Corman, together with Senator Edward M. Kennedy (D-MA) cosponsored the Health Security Act of 1977. □



SEN. KENNEDY in July, 1978.



(Photo by Claude Brooks, Owings Mills, MD.)

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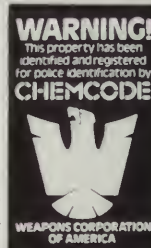
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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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**When painful spasm
is the presenting
symptom...**



... in functional G.I. disorders*

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(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition. It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdose, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage. Bentyl 10 mg. capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) **Bentyl 20 mg.:** Adults: 1 tablet three or four times daily. **Bentyl Injection:** Adults: 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

Merrell

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Medical Miscellany

Clinical Center Study of Patients Requiring Orthognathic Surgery

The cooperation of physicians and dentists is requested in the referral of patients in need of orthognathic surgery for a study being conducted by the National Institute of Dental Research, the National Institutes of Health, Bethesda, MD.

To be eligible for the study, patients must be between the ages of 15 and 45 years and in good physical and mental health. They must have a dentofacial deformity and/or severe malocclusion with an essential cosmetic component that requires surgical correction as well as orthodontic therapy. Patients with Class II or III malocclusions, apertognathia and severe facial asymmetry are included. Patients selected for this study must be available for treatment and follow-up at the clinical Center for approximately three years.

All patients who are referred will undergo a screening examination, orthodontic work-up and psychological evaluation by NIDR staff members to determine final acceptability.

To refer a patient or obtain further information, please call or write James B. Sweet, DDS, MS, Bdg. 10, Rm. 1B-20, National Institutes of Health, Bethesda, MD 20014; phone (301) 496-4371.

Patients Needed

The National Cancer Institute-VA Medical Oncology Branch, located at the Veterans Administration Hospital, Wash., DC, requests your cooperation in referral of veteran or non-veteran patients with the following malignancies:

1. *Small Cell Carcinoma (Oat Cell or other small cell varieties) of the Lung* for treatment with intensive chemotherapy. Patients should not have received prior chemotherapy or radiotherapy.

2. *Epidermoid (Squamous) Carcinoma and Adenocarcinoma of the Lung* for treatment with chemotherapy. The patient should have unresectable disease, be fully ambulatory, have no prior treatment with radio- or chemotherapy and have evaluable lesions.

3. *Hepatocellular Carcinoma (Hepatoma)* for treatment with chemotherapy and hormonal therapy or consideration of combined chemotherapy and surgery for local disease.

4. *Advanced Prostatic Carcinoma (Stage D)* for treatment with chemotherapy and hormonal therapy. Patients who have failed estrogen therapy are eligible.

5. *Multiple Myeloma—Waldenstrom's Macroglobulinemia, Heavy Chain Disease and related monoclonal gammopathies* for combination chemotherapy treatment. Patients who have received no prior chemotherapy are eligible.

6. *Cutaneous T-Cell Lymphomas—including Mycosis Fungoides and Sézary Syndrome* for treatment with electron beam radiotherapy and/or chemotherapy. Patients

with all stages of disease are eligible.

7. *Non-resetable or recurrent Gastric Carcinoma*—for treatment with combination chemotherapy. The patient should have unresectable disease, be fully ambulatory, have no prior chemotherapy and have evaluable lesions. Patients who have received radiation therapy are eligible.

The referring physicians will be kept fully informed as to the results of treatment and are encouraged to participate in the follow-up care of their patients. In addition, the Branch is serving as a lung cancer pathology reference center.

To refer a patient or to obtain further information, please call or write Dr. Martin H. Cohen, Dr. Daniel C. Ihde, Dr. Paul Bunn or Dr. John Minna: NCI-VA Medical Oncology, 2CN, Veterans Administration Hosp., 50 Irving St., NW, Wash., DC 20422; phone (202) 389-7275 or 7558.

American Doctors Lead Victory Over Yellow Fever

Within the lifetime of some Americans still living today, yellow fever was a feared and dreaded disease that swept American cities from time to time, striking tens of thousands and taking many lives.

Yellow fever likely was brought to the Americas in the 16th Century from the Old World. In America, it became a feared scourge, and New World doctors were the first to study the disease.

Dr. John Crawford of Baltimore is credited by medical historians as first determining that mosquitoes were the source of malaria, yellow fever and other diseases. Dr. Crawford clashed vigorously with the famed Dr. Benjamin Rush, a signer of the Declaration of Independence, who believed that yellow fever was caused

by something foul in the air.

Dr. Carlos Juan Finlay of Cuba, in experiments in the 1880s, tested the theory that the *Aedes Aegypti* mosquito was the transmitter of yellow fever. Taking off from Dr. Finlay's inconclusive work, a US Army Medical team led by Dr. Walter Reed in 1901 showed once and for all that the mosquito was the culprit in a medical experiment that was the theme of a famous Broadway play of a generation ago, *Yellow Jack*.

It fell to William Crawford Gorgas of the Army Medical Corps to demonstrate that he could stop yellow fever in Havana by eradication of the mosquito from the swamps and waterways of the Cuban capital. Gen. Gorgas repeated his success in Panama, making possible the digging of the Panama Canal by laborers freed from the hazard of the serious disease.

Gen. Gorgas later headed the Rockefeller Foundation Yellow Fever Commission that wiped out the disease in many Latin American countries and worked on the problem in Africa, and in the late 1930s a researcher at the Rockefeller Foundation laboratories perfected a vaccine against Yellow Fever.

The last epidemic in the US was in New Orleans in 1905, causing more than 400 deaths and almost 3,500 cases. New Orleans had neglected to carry out a mosquito-eradication campaign, but after the epidemic, moved to eliminate the breeding areas.

Ironically, at an international medical meeting some years ago, the Republic of Panama pointed out that the *Aedes Aegypti* mosquito still flourished in some Southern states of the US, and that all that was needed for another outbreak was for an infected individual to come into a Southern airport from abroad and be bitten by a mosquito. An eradication campaign was ordered. □

Doctors Take Note

Maryland Area: The Free State

Georgetown University Medical School

For details, call Dr. Dean Schuyler, (202) 625-7354. All talks 8-10 PM, Rm. LA-2, Basic Sci. Bldg., GU Med. Campus, 3800 Reservoir Rd., NW, Wash., DC 20007.

Jan. 26, 1-5 PM, **Psychology of the Hostage-Taking Situation: A Symposium on Terror.**

The Johns Hopkins Medical Institutions

Jan. 31-Feb. 2, 1979 **Update in Surgery**, 21½ Cat. 1 cred. hrs. (For details, call (301) 955-8450.)

Feb. 15-16, 1979 **Cardiopulmonary Nuc. Med.** (Call above.)

March 7-13, **Update in Obstetrics**, 1979, Caribe Hilton, San Juan, PR. For details, call (301) 955-5880.

March 12-16, **Management of Obesity**, for 32 cred. hrs. of AMA Cat. 1, Physician's Recog. Award.

March 15-17, **J. Donald Woodruff Symposium on Gynecologic Oncology.**

March 19-21, **Spectrum of Developmental Disabilities in the Preschool Child: Issues in Detection and Trtmt.**

March 22-23, **Diag. and Trtmt. of Neoplastic Disorders.**

March 26-30, **Practical Cardiology for the Practicing Anesthesiologist.**

Apr. 2-7, **Pediatric Trends**, 1979.

Apr. 9-10, **Psychiatric Update**, 1979: Topics in Contemporary Psychiatry.

Mercy Hospital

Feb. 2-3, **Diagnostic Laparoscopy** at Del Webb's Townehpuse, Phoenix, AZ. For details, call Vernon M. Smith, MD at (301) 332-9412.

University of Maryland

Feb. 1-2, **Burn Workshop**, Baltimore Hilton Inn. For details, call (301) 528-3956.

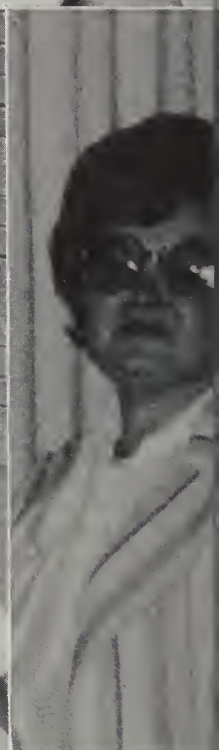
March 1-Apr. 5, **Selected Topics in Family Practice.** For details, call (301) 528-3956.

March 9-10, **Gastroenterology for the Primary Care Physician**, Cross Keys Inn, Columbia, MD. For details, call number above.

Other Maryland Meetings

March 7, **Handling Patients Seeking Plastic Surgery**, talk by Frederick C. Hansen, MD. For more data, call Ms. Karen Lane, CMA-AC, (301) 821-5222.

Apr. 4, **New Trends in OB/GYN**, talk by Gerald Glowacki, MD. For details, call Ms. Karen Lane, CMA-AC, (301) 821-5222. □



Auxiliary

MRS. THOMAS F. HERBERT
President

MRS. R. KENNEDY SKIPTON
Editor

LEFT—(From left to right, top row) **MRS. BERNARD KARPERS, JR. (KATHY)**, Baltimore City; **MRS. H. PATRICK ADAMS**, (Talbot County); **MRS. MEHDI YEGANEH (FRANCES)**, Baltimore County; **MRS. ROBERT BROADDUS (CAROL)**, Harford County; (Middle row, from left to right) **MRS. ANSELMO MAMARIL (MYRNA)**, Howard; **MRS. RONALD KRETKOWSKI (VICKY)**, Prince George's; **MRS. LEO FRANKLIN (URSULA)**, Allegany; **MRS. DANIEL M. HOWELL (NANCY)**, Charles; (Bottom row, from left to right) **MRS. DANIEL McCABE (MARNIE)**, Anne Arundel; **MRS. H. W. HIEHLE (LOUISE)**, Washington County; **MRS. THOMAS BERRY (BETTY)**, Wicomico and **MRS. ERNEST HARMON (ELSIE)**, Montgomery.

Some Other Views . . .

(All photos courtesy of the Auxiliary.)



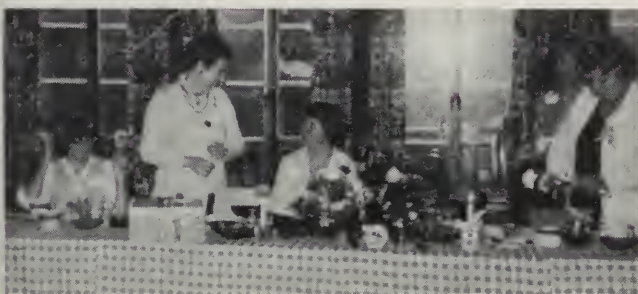
1978 ANNUAL MEETING AT HUNT VALLEY: Mrs Helen Boyer (right) pins Mrs. Carol Broaddus (center), as Mrs. Hoyt Gardner (left) looks on.



JUNE, 1978, AMA AUXILIARY MEETS in St. Louis, MO (left) Mary Strauss and (right) Kassie Herbert.



ST. LOUIS MEETING (from left to right): Mary Skipton, Kassie Herbert, Mary Strauss and Helen Boyer.



MONTGOMERY COUNTY INSTALLATION LUNCHEON (l. to r.): Sandy Peskin, Marty Perez, Kassie Herbert, Elsie Harmon (partially hidden) and Norma Flaherty.



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Your Medical Faculty At Work

JOHN SARGEANT, CAE, Executive Director

Executive Committee

The Executive Committee met on Nov. 2, 1978 and took the following actions:

1. Approved loan of the bronze Frank Frick plaque now in the Faculty Library to the Walters Gallery for an exhibition during the period of January through March, 1979.

2. Authorized development and implementation of a program for Physician pre-retirement and retirement by the Committee on Physician Rehabilitation.

3. Authorized a personnel study which would establish minimums and maximums for employees by position, as well as development of job descriptions and other details involving personnel policy.

4. Heard a report on the Inter-Agency Council activity and authorized, in principle, the participation by the Faculty of peer review of in-hospital medical care, subject to development of appropriate guidelines in this connection.

5. Approved participation in a 13-week talk show in WBJC-FM every other Wednesday and authorized expenditure of funds to cover production costs of the show.

6. Approved participation by submitting a nominee to serve on a new State Education Department Committee on Nutrition Education and Training Program. □

Council

The Council met on Nov. 30, 1978 and took the following actions:

1. Designated the firm of Anderson, Coe and King as legal counsel for 1979 under the same terms and conditions as in 1978.

2. Established Council meeting dates for 1979.

3. Approved waiver of dues for individual members on the recommendation of their component society.

4. Approved, at the request of the appropriate component society, a recommendation to the House of Delegates for Emeritus Membership for four physicians.

5. Approved a proposed fundraising project of the Library to provide additional medical journal subscriptions.

6. Received a report dealing with a proposed Consortium of Hospital Medical Libraries.

7. Adopted the following policy position in connection with Home Deliveries:

"Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and

fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.

"We recognize, however, the legitimacy of the concern of many that the events surrounding birth be an emotionally satisfying experience for the family. The Medical and Chirurgical Faculty of the State of Maryland supports these actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety available only in the hospital."

8. Approved a recommendation of the Committee on Preventive Medicine and Public Health that would ban smoking in public places, and referred this to the Legislative Committee for drafting of appropriate legislation and its introduction into the 1979 General Assembly session.

9. Approved a recommendation of the Physician Rehabilitation Committee that Baltimore be offered to the AMA as a site for the Fourth Annual Conference on the Impaired Physician.

10. Designated Alva S. Baker, MD, Westminster, to serve on the Program and Arrangements Committee through the 1979 Annual Meeting.

11. Rereferred to the Jail Project Advisory Committee its proposed **Guidelines for Jail Facilities and Equipment** with some specific suggestions for changes and a request that such guidelines be redrafted and submitted for approval.

12. Approved submission of the name of R. Adam Cowlep, MD of Baltimore as a nominee for the AMA Sheen Award.

13. Declined to adopt a recommendation of the Policy and Planning Committee dealing with Maryland Blue Shield and authorized the President to name an Ad Hoc Committee to meet with Blue Shield representatives and attempt to resolve what appears to be some deficiencies in the relationship of Blue Shield with individual physicians.

14. Adopted the following resolution:

WHEREAS, It has long been the objective of the medical profession that patients receive the highest quality of medical care and services and

WHEREAS, The Medical and Chirurgical Faculty of the State of Maryland's policy is that the interests of the patient are paramount in receiving medical care and services and

WHEREAS, The Faculty has also adopted the position that a physician has the right to select whom he serves, except in the case of emergency, when he should make his services available if they are needed, and

WHEREAS, The proposed settlement in the Pennsylvania chiropractic suit against various specialty and state medical societies, as well as the American Medical Association, provides for these principles, be it therefore

Resolved, That the Medical and Chirurgical Faculty supports the action of the AMA Board of Trustees in its decision to terminate the AMA's involvement in the litigation currently taking place in Pennsylvania and be it further

Resolved, That the Faculty's Delegates to the AMA House of Delegates introduce the above resolution at the Interim Session of the AMA House of Delegates.

15. Adopted a position paper on Second Opinions. (This is published in full at the end of this report.)

16. Approved Faculty sponsorship of TelMed with no financial commitment involved, such sponsorship being for planning purposes only.

17. Authorized the President to name an Ad Hoc group to review present HMO activities and to ascertain if policies are being followed that are detrimental to patient care and the public. The group will make a report to the Council.

Recommendation from the Physician/Patient Relations Committee adopted by the Council, Nov. 30, 1978

Second Opinion Position

Upon direction from the Council, the Committee revised the Second Opinion document to apply to the entire practice of medicine rather than specifically to surgery. In addition, the Committee reduced the policy statement in size by deleting several areas which addressed the issue of unnecessary surgery. The revised statement is as follows:

The Faculty recognizes third-party carriers for making second opinions available to subscribers; however, second opinions should be sought at the request of the patient or physicians rather than be mandatory. A mandatory program may increase the potential for legal liability on the part of physicians. Where a bad result occurs and there is a difference of opinion between two competent physicians, one of the two may find himself faced with a lawsuit because retrospectively one may have been right and the other wrong. We have learned that litigation tends to aggravate the cost of medical care. Prudence, not compulsion, in seeking consultation is in the patient's best interest. (See *Infra*: Principles of Medical Ethics.)

The Faculty further recommends that the consultants considered for second opinions not be deemed qualified solely on the basis of Board Certification or other specialty society memberships. Expertise should be deemed to be present, *de facto*, where there is training and experience at least equal to that of the physician whose treatment is the subject of the consultation.

There are basic principles that must be recognized in any program offering the patient a choice of a second opinion.

1. The patient should select the consultant and likewise should select the physician who will render the treatment if indicated. In no case shall the consultant physician treat the patient without the knowledge of the original physician.

2. The establishment of a fixed fee for the second opinion or consultation and the requirement that the physician accept this as payment in full cannot bind the physician unless he agrees with this concept. Physician consultants shall not be limited to only those who

agree to the fixed fee, nor shall the patient's choice of consultants be limited to any such physicians.

3. The method of payment for the service shall remain the prerogative of the consultant physician; that is, he shall be free to bill the patient directly, bill the insurer directly or obtain an assignment of payment from the patient.

4. The attending physician must be advised that a second opinion is being sought, and must be advised by the consultant physician of the substance of his opinion in writing.

Finally, the Faculty endorses the principles of medical ethics, as enumerated by the AMA:

"Section 8: A physician should seek consultation upon request, in doubtful or difficult cases or whenever it appears that the quality of medical services may be enhanced thereby." □



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 Sept. 12-16, 1979—Royal Sonesta Hotel—New Orleans, LA

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Maryland Hospital Association Speaking of Hospitals

RICHARD J. DAVIDSON, Editor

Future Shock

By RICHARD J. DAVIDSON

Mr. Davidson is President of the Maryland Hospital Association, 1301 York Rd., Lutherville, MD 21093.

If we view our world from afar, it continues to move at the same speed it always has, but a closer look reveals that everything in our world moves at an ever more dizzying pace. Things change, sometimes faster than we would like, frequently before we are prepared to accept or cope with the change.

Hospitals and health professionals today face problems that are rooted in social, political and economic change. Hospitals are called on to reach out and serve larger community health needs. Physicians are deprived of the necessary time to practice their specialty with care and compassion. The health manpower revolution has created new kinds of jobs that never existed before.

Of course, all of us are familiar with rising costs and the alleged problem of excess beds, and there is the growing spectre of government regulation that comes with increased government funding.

Before taking a closer look at these changes, it might be worth our time to look at what we have been before looking at what we are about to become.

The modern hospital bears little resemblance to the hospital of the past. Today's hospital is a place of recovery. Up until the middle of the 19th Century, hospitals were considered as nothing more than places to die, usually in pain and suffering and alone.

In 1889, our own Johns Hopkins was among the first hospitals to set a new standard of healing based on science. That touched off a continuing demand for better, more efficient treatment and care, and that brought on the era of the specialist. The specialist brought new problems — communication problems. Specialization was keen, precise and efficient, but often impersonal.

Hospitals built since the 1960s, reflecting the age of the specialist, stressed technology in the care of the patient, but as the demand for the newest technology grew, so did the effects of inflation. Something fundamental was happening and it threatened to spin the system out of control. New rules, new perceptions were called for.

As inflation and consumer unrest soared, there came a torrent of new Federal health care legislation beginning with the 1965 Medicare and Medicaid Acts. That same year, Congress enacted regional medical care programs. The Comprehensive Health Care Planning Act came in 1966. In 1972, came standards for Professional Standards Review Organizations and, in 1973, the Health Maintenance Organization Act.

Now we are involved in a great debate over National Health Insurance, but, careful observers say the legislation hasn't a chance until the health care system, through internal reform, finds a way to control costs.

The difficult question we all face is how to control costs while improving care. The problem is all the more difficult as we discover that chronic disease is as much a product of lifestyle and mental attitude as it is of external disease agents. Meeting that challenge is, as Lewis Mumford said, "Akin to recomposing the score while conducting the symphony."

Something new is needed to take control of this fast-changing system, and that is a greater sense of cooperation between physician, hospital chief executive and trustee. The physician-specialist, overwhelmed by the growing complexities of his/her profession, needs to appreciate the support available from the trustee and the chief executive; support that allows him/her to focus on the specialty practice.

Changed, too, is the role of the hospital chief executive, who must reach out — from his/her own hospital — from neighboring hospitals — to the entire health care system. Without proper care and maintenance, a vital part can break down; and, when that happens, the entire system can be threatened.

Finally, the role of the trustee has changed. He or she is more than a lawyer, business executive or sometime booster. This is the dawning of the era of the skilled hospital trustee, whose caring and guiding hand leads the hospital through the tangle of legal, economic and regulatory uncertainties generated as a result of consumer demands and scrutiny by local, state and Federal watchdogs.

The point is: the ballgame has changed and all of us must understand those changes if we are to guide the evolution of the hospital into higher standards of care and community well-being.

To do that will require that all of us work together to avoid the trauma of future shock. □



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Medical Miscellany

Fund for Those Under 18

The Children's Hospital in Baltimore has a fund known as the Stanley Phelps Fund, available for treatment of persons under the age of 18.

The guideline for persons to qualify for this fund is that they must be medically indigent, or they

may need further financial assistance.

There is a simple eligibility form to be completed at the time of application, and presented to the Committee for approval.

If you know of any patients who would qualify for help from this fund, please refer them to the Children's Hospital, Social Service Department, 3825 Greenspring Ave., Balto., MD 21211 or Miss Margaret E. Garrett.

Raymond V. Rangle, Esquire is Chairman of the Phelps Committee. ☐

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Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.

However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).



Motrin[®] 400mg^{TABLETS}

ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

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one more reason to prescribe

Motrin 400 mg TABLETS

ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%, *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

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Bottles of 60

Bottles of 500

NDC 0009-0733-01

NDC 0009-0733-02

Motrin Tablets, 400 mg (orange)

Bottles of 60

Bottles of 500

Unit-dose package of 100

Unit of Use bottles of 120

NDC 0009-0750-01

NDC 0009-0750-02

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient b.i.d. dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

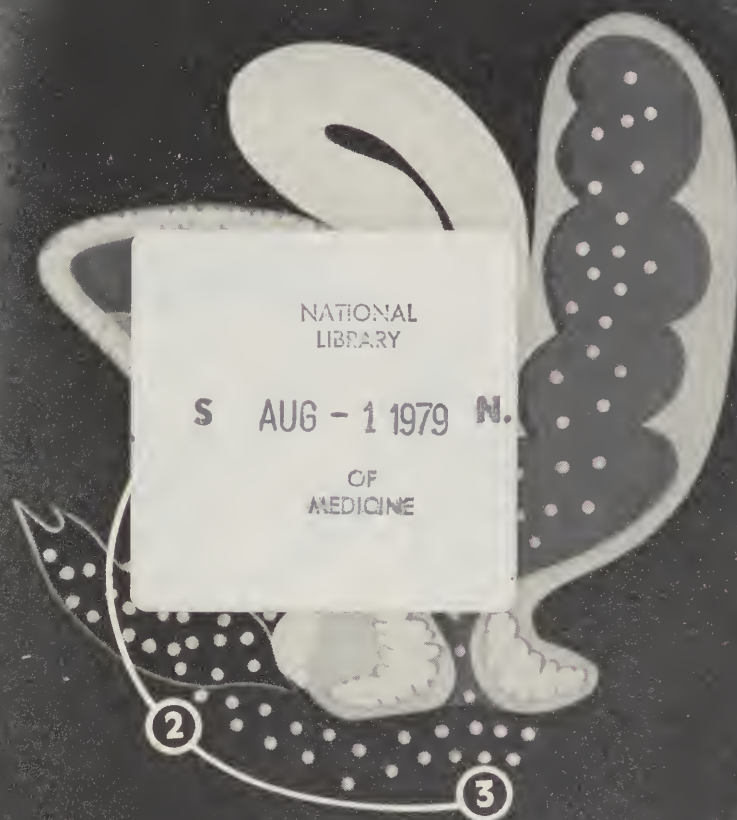
Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.



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Health in History

**Was Jack the Ripper
Heir to the British Throne?
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Tennis (Injuries) Anyone?
... see page 32



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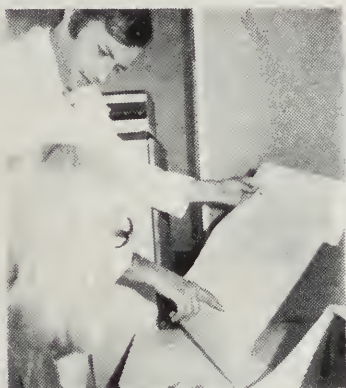
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malforma-

tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



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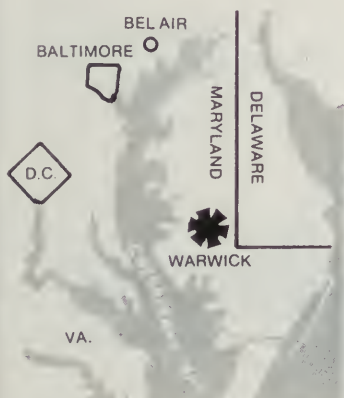


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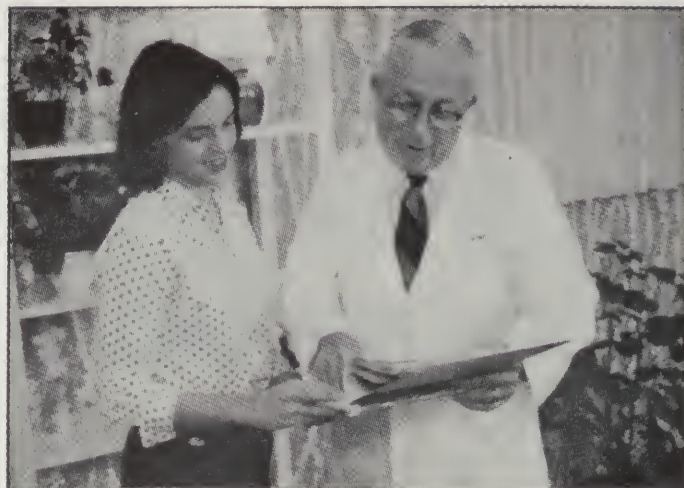
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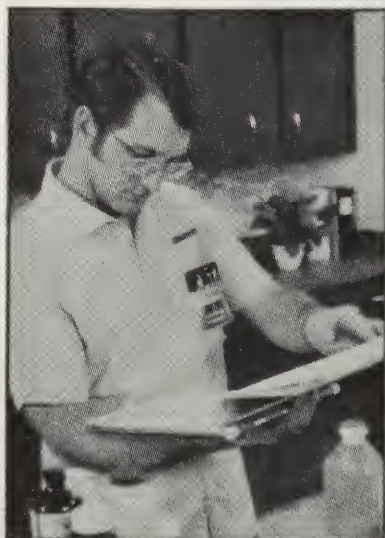


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MARYLAND STATE MEDICAL Journal

Volume 28

FEBRUARY, 1979

Number 2

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EDITORIAL and BUSINESS OFFICE:
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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

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TENNIS—as here played by doctor's wife Denise Courtney-Kenyon— is the subject of this month's **Library Page** feature on page 32.

(Pix by Paul F. Schlining, Jr.,
Phoenix, MD.)

Cover photo by PFS; artwork by
Claude Brooks, Owings Mills, MD.

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



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- Fast — only seconds to perform — can be read in 48-72 hours.



Precautions: Tuberculin testing should be done with caution in persons with active tuberculosis. However, activation of quiescent lesions is rare.

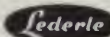
Although clinical allergy to acacia is very rare, this product contains some acacia as a stabilizer and should be used with caution in patients with known allergy to this component. Reactivity to the test may be suppressed in patients who are receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles.

With a positive reaction, further diagnostic procedures must be considered. These may include x-ray of the chest, microbiologic examinations of sputa and other

specimens, and confirmation of the positive TINE TEST using the Mantoux method. In general, the TINE TEST does not need to be repeated. Antituberculous chemotherapy should not be instituted solely on the basis of a single positive TINE TEST.

Adverse Reactions: Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.

Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.



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The Open Forum

"Informative and Entertaining"

To the Editor:

Your **Journal** is to be commended for always being informative and entertaining. Of special interest to me are the articles on **Health in History** by Blaine Taylor. The most recent one, entitled **Some Medical-Historic Aspects of the Later Napoleonic Wars, 1812-15** (December, 1978); was fascinating.

The anecdote about the Earl of Uxbridge and the loss of his leg gave an insight into the indifference to danger and stoicism displayed by the British Officer Corps during those days. The story brings to mind a similar one about Lord Raglan, who was the Commander-in-Chief of the British Army in the Crimean



THE EMPEROR NAPOLEON I
and signature.

War of 1854. As a young officer at the Battle of Waterloo, his right arm was amputated, without anesthetic of course, on the field of battle. After the amputation, he called out, "Here, don't take that arm away until I have taken the ring off the finger!"

(Reference: Cecil Woodham-Smith: **The Reason Why**; McGraw Hill, 1954, p. 163.)

JOHN R. NORRIS, MD

Manley, Ferciot, Norris, MDs, PA
2045 York Rd.,
Timonium, MD 21093.

Med-Chi Applauded

To the Editor:

On behalf of the American Lung Association of Maryland, I would like to applaud the decision of the Medical and Chirurgical Faculty of Maryland to endorse a policy of "no smoking" at all business and professional meetings of the Faculty.

In a motion recently recommended by the Faculty's Committee on Preventive Medicine and Public Health, it is pointed out that because smoking is "Irritating, noxious and hazardous to both smokers and non-smokers," physicians should set an example by their habits and behavior which serves as a model for the maintenance of health habits in the community.

Second-hand smoke has higher concentrations of noxious compounds (tar, nicotine, carbon monoxide, ammonia and three-four benzpyrene—which is suspected as a cancer-causing agent) than the smoke which the smoker pulls through the cigar or cigarette when he/she inhales. This concentration not only can cause eye irritations, headaches and allergic reactions, but can aggravate the condition of a person with chronic bronchitis and emphysema as well.

Med-Chi's action is admirable.

SUSAN MATHER, MD

President
American Lung Assn. of MD, Inc.
11 E. Mt. Royal Ave.,
Balto., MD 21202

WHAT DO YOU THINK OF THE JOURNAL?
Let us know! Write Open Forum,
JOURNAL,
1211 Cathedral St., Balto., MD 21201.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of the State of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to the Physician Placement Service, 1211 Cathedral St., Baltimore, MD 21201; telephone 1-301-539-0872.

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

Journal announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

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For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

Doctors in the News

Dr. Marvin Mones Named "Pediatrician of the Year!"

Marvin Mones, MD, an original organizer of Holy Cross Hospital prior to its opening in Silver Spring in 1963 and one of its Past Presidents, was named Pediatrician of the Year by the Montgomery-Prince George's County Pediatric Society recently. He received the award from outgoing Society President Larrie W. Greenberg, MD.

A Fellow of the American Academy of Pediatrics, Dr. Mones was cited for his "Unselfish contributions and devotion to pediatrics, locally, within the state and nationally."

In addition to his private practice which he established in 1950, Dr. Mones is currently active in the Academy—as a member of its Legislative Issues Committee, as an Alternate Chairman of its District III (MD, DE, WV, NJ, PA)



DR. MARVIN MONES

and as a member of its task force on national health planning.

He is also a member of the State Health Coordinating Council—Maryland's chief health planning agency—concerned with the availability of economically feasible health care for all.

On the occasion of this award, Dr. Mones acknowledged gratitude to his peers, the satisfaction of 28 years of service to his patients and the need for all pediatricians to actively participate in the shaping of the future of health care.

Dr. Antlitz Takes Charge

Albert M. Antlitz, MD was installed as President of the 1,680-member Baltimore City Medical Society at the Society's Annual Meeting in December, 1978. Dr. Antlitz is a graduate of Georgetown University Medical School and received his postgraduate training in medicine and cardiology at Mercy Hospital and the University of Maryland. He was appointed to his present position of Head of the Division of Cardiology of Mercy Hospital in 1962.

Dr. Antlitz has been active in both the City and State medical societies, serving on the Medical and Chirurgical Faculty Council and Executive Committee and on the City Society's Board of Directors. He is also a member of the Governing Body and Executive Committee of the Central Maryland Health Systems Agency and is Chairman of the Systems' Development Committee.

Other officers elected by the Society were Henry N. Wagner, MD, President-elect; Leon E. Kassel, MD, Vice President; Karl H. Weaver, MD, Secretary and Kennard Yaffe, MD, Treasurer. Elected to the Board of Directors were: Drs. Raymond M. Atkins, Frank L. Iber, Misbah Khan and Samuel M.M. Lumpkin. □

Doctors in the News continued on pp. 13, 50, and 69.

Coming in the Journal:

**NURSING BOTTLE
SYNDROME,**
by Sol B. Love, DDS

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M. McKendree Boyer, MD, 1907-78

Maryland lost one of its most outstanding Family Physicians in 1978 when M. McKendree Boyer, MD, of Damascus, MD died from complications arising from surgery. Dr. Boyer, or "Mac" as he was affectionately known to all his friends and patients, came from a family of physicians. It is hoped this line will continue with his son, George, who is currently a freshman at the University of Maryland School of Medicine.

Dr. Boyer served as President of the Medical and Chirurgical Faculty of the State of Maryland in 1963-64 and as an Alternate Delegate to the American Medical Association House of Delegates from Maryland since 1965.

Born in 1907, he was a graduate of the George Washington University School of Medicine in 1931, trained at St. Luke's Hospital in Cleveland from 1931-35 and carried out postgraduate work in London, England and Vienna, Austria. He commenced General Practice in Damascus in 1935, joining his father, with whom he practiced for many years.

Almost immediately on joining the Montgomery County Medical Society, of which he served as President in 1943, he became active in medical society affairs. He served in numerous capacities at the local level, and when he had exhausted the positions he could hold there, became active on a state level. He was elected Faculty President by unanimous vote of the House of Delegates at the Annual Meeting in 1962.

Dr. Boyer's empathy was well-expressed when he established the George M. Boyer, MD Lectureship Fund for his fellowman in memory of his father. He stated at that time:

"Dr. Boyer (George) had no special claim to fame, but was much beloved by and respected by not only his patients, but by the people of his community and county as well."

These apt words apply equally to "Mac" Boyer as they did to his father, and no person could have expressed them more cogently.

In a 1964 issue of the *Journal*, Dr. Boyer spoke to *The Changing Image of the American Physician*. In this article, he referred to his father again by saying:

"He was a self-effacing, gracious gentleman with the highest moral integrity. He combined his knowledge of medicine and his keen understanding of people with a warm and sympathetic personality to stimulate the confidence of his patients. He had utter disregard for personal comfort or for financial remuneration. The gratitude of an appreciative patient was adequate compensation."

Once again it is as though he were talking about himself, for all these attributes belong to the son as well. Truly, the Biblical words, "In his own Image" apply here.

Dr. Boyer did not confine his activities to the medical field or profession. He served as a member of the Board of Stewards of the Damascus Methodist Church, as a Vice President of the Bank of Damascus and as a member of the Damascus Lions Club and with numerous other civic organizations, also.

"Mac" will be sadly missed by all but, most importantly, his memory will live forever.

He is survived by his wife, the former Helen Warfield Souder and three children: Sally Ann, George and McKendree.



DR. BOYER

Coming in the Journal:

PROPHYLAXIS OF THROMBOEMBOLIC DISEASE,

by Matthew J. Gibney, III, MD

PERITONEAL ADHESIONS: WHERE DO WE STAND?

by Abdallah Alameddine, MD



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A RECENT MEETING OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION was held at the Eastern Regional Health Center with the Franklin Square Hospital Staff as hosts. A delicious supper was served, following a social hour, provided by the hosts. The speaker was **Lawrence Blumberg, MD**, (above) a member of the Association and Orthopedic Surgeon at Franklin Square, whose subject was **Current Concepts of Total Joint Replacement**. This is a very timely subject and the attendance was excellent for this scientific meeting.

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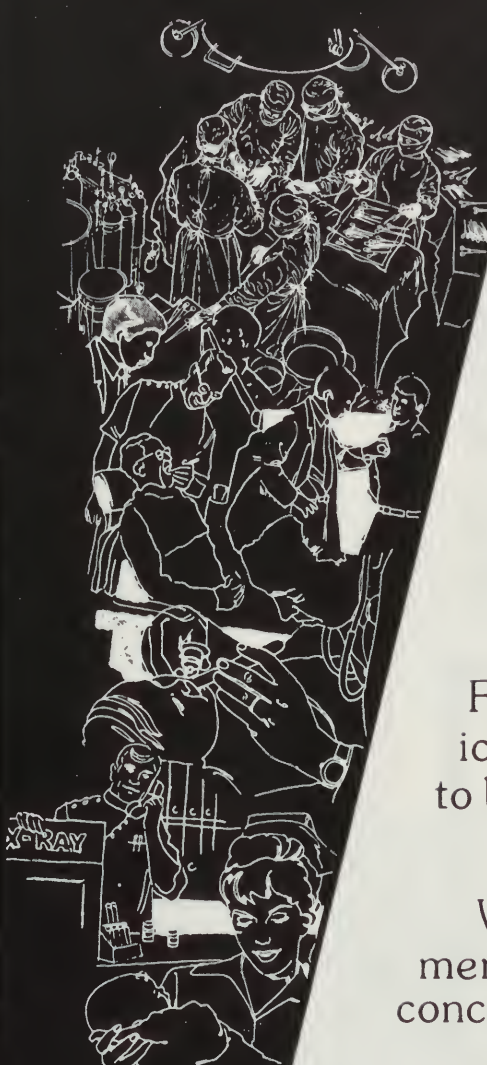
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Executive Director's Newsletter

February, 1979

DEFINITION OF PHYSICIAN ASSISTANTS' SUPERVISION	<p>The Board of Medical Examiners has advised the following in connection with the definition of supervision of Physician Assistants:</p> <p>"It is the position of the Board that supervision of non-physician practitioners means "direct supervision," i.e. on-the-spot or on-the-premises and does not mean indirect supervision. It was not intended, nor is it now intended that the non-physician practitioner be placed in a position to make independent decisions regarding diagnoses or treatment of the ill patient. Under circumstances as stated in the individual job description, the non-physician practitioner may be assigned duties according to a prepared protocol, he/she may transmit specific orders from the physician given by telephone but the regulations state that 'no physician may delegate the ultimate responsibility for diagnosis or therapy.' Since the delegation of duties does not relieve the physician of his primary responsibility to the patient for his care and treatment, the physician must maintain direct supervision."</p>
AWARD MADE	<p>William L. Stewart, MD, formerly of Westminster, Maryland, and now Chairman of the Department of Family Practice at the Southern Illinois University School of Medicine, has been awarded the Thomas W. Johnson Award for Outstanding Contribution to Family Practice. The award was made in San Francisco at the Congress of Delegates meeting.</p>
CYTOPATHOLOGY REFRESHER COURSE	<p>April 23-May 4, 1979, are the dates for the Twentieth Post-graduate Institute for Pathologists in Clinical Cytopathology to be held at the Johns Hopkins Hospital and The Johns Hopkins University School of Medicine.</p> <p>The program designed for Board eligible or certified Pathologists or equivalents, is an intensive refresher in all aspects of this clinical area. Newer techniques, special problems and recent applications will be covered in lectures, explored in informal conferences and discussed over the microscope with the Faculty. Self-instructional material will be available to augment at individual pace. A loan set of slides with text will be sent to each participant for home-study during March and April before the Institute. Credit hours - 120 in AMA Category 1.</p> <p>Application is to be made before February 28, 1979. For details, write to John K. Frost, M.D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Maryland 21205.</p>

NEW LAWS, RULES
AND REGULATIONS

The latest issue of Laws, Rules and Regulations With Which Physicians Must Comply is now available on request. This latest compendium has been modified over previous issues with deletion of outdated material and references only to lengthy opinions that can be obtained also on request.

ANNUAL MEETING

DATES

The Annual Meeting in 1979 will be extended by one-half day. The meeting will commence on Wednesday, May 2, 1979, at 9:30 AM with the customary House of Delegates session and will adjourn on Saturday morning, May 5, 1979, with the concluding House session.

The Presidential Dinner will take place on Friday evening, May 4, 1979, following the scientific sessions which will conclude in the late afternoon that same day.

Full details will be in the mail shortly to all members.

RESOLUTIONS

DEADLINE

The bylaws of the Faculty provide that resolutions to be submitted to the House of Delegates at the Faculty's Annual Meeting must be in the Faculty office eight weeks before the date of the Annual Meeting.

The dates for the Annual Meeting are May 2 through 5, 1979; therefore, resolutions must be in our hands by

FRIDAY, MARCH 9, 1979.

MEDICAL GROUP

MANAGEMENT

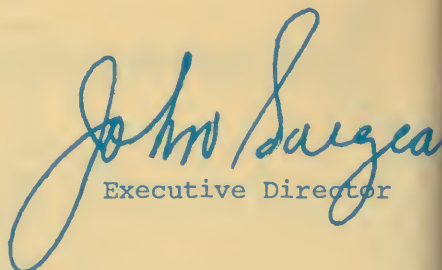
ASSOCIATION

Raymond G. Hohman, Jr., current president of this organization, has advised that some 50 persons are members of the group. Covering the Maryland/DC area, programs for five meetings during 1979 have been established. Further information can be obtained from Mr. Hohman at 4940 Eastern Avenue, Baltimore, Maryland, 21224, phone 342-2813.

DOCTORS

ON THE AIR

Faculty physicians are participating in a radio talk show over WBJC-FM, 91.5 on the dial. The program is called "Consultation" and can be heard on alternate Wednesdays at 6:30 PM.


Executive Director

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Medicine in Maryland, 1634–1900

Editor: Douglas G. Carroll, Jr., MD (1915–1977)

Chapter 13: Care of the Insane in Maryland, 1841

Dr. A.C. Robinson's 1841 report on the insane at the Baltimore Alms House is important because it reveals so clearly the current theories, classification, treatment and prognosis of the mentally-ill.¹

Alexander C. Robinson (1810–71) (AB, Yale, 1830; MD, Maryland, 1832) was a visiting physician at the Alms House for many years.² In 1841, on the death of William Nelson Baker (1811–41), lecturer in Anatomy, N.R. Smith urged the candidacy of Dr. Robinson for this position, but others believed he lacked experience.³

In the report, Robinson is much influenced by English (Ellis) and French (Esquirol and Pinel) views on the care of the insane.⁴ He also quotes extensively from the 1833 Annual Report of the Worcester State Lunatic Asylum.

Theory of Insanity

He looks on insanity as the result of "astonishing thought, that they (the insane) are neither able properly to direct or control." He does not attempt diagnostic classification. In the Table showing the list of patients, their behavior is described, rather than classified.⁴ Thus, he differs from Benjamin Rush, who attempted to fit all insane patients into diagnostic categories. The influence of the French and English clinicians is also shown in his emphasis on the personal comfort, need for intelligent attendants and appropriate occupations and amusements for the inmates. This was a manifestation of "moral" treatment advocated by Philippe Pinel (1755–1826) in France and William Tuke (1732–1822) in England. "Moral" meant psychological or non-organic. It was a result of the change in attitude toward man's responsibility for his acts.

The old idea that a man was possessed by devils, and somehow guilty, changed to a belief that the insane person was unable to control himself, and therefore not guilty and should not be punished.⁵

Method of Treatment of Patients

Essentially, Robinson followed the precepts of "moral" treatment: personal involvement with the patients, pleasant surroundings, intelligent attendants and special architectural features for patients having different problems. Furthermore, each patient should be kept as busy as possible: working on the farm if inoffensive and able-bodied; confined if violent. Occupation and amusement should be available where needed.⁶

Prognosis for Cure of the Insane

Robinson acknowledged the poor outlook for many of

the insane. He concentrated on the cures which occur in those with recent onset of insanity.

Need for Pauper State Lunatic Asylum

Because of the mixture of all types of patients, needing different kinds of restraint and different occupations, Robinson felt that the Alms House was an inappropriate place for the insane, and recommended a State institution.

It was possible to segregate the black patients, but not the different categories of insane.

Taken as a whole, Robinson's report is an accurate description of care and treatment of the insane in Maryland just prior to the Civil War.

Jan. 20, 1841—Abstracts from "*The Report of The Lunatic Department of the Baltimore Alms House*," presented by A.C. Robinson, MD.¹

Gentlemen:

The arrival of a period appointed for your annual report of the condition and conduct of this Institution—benevolently designed for the accommodation of the Poor for our city and county—has suggested the propriety of presenting the accompanying statement relating to the insane inmates, to its various particulars your attention is solicited.

You will all probably coincide in the opinion that the insane department is the only portion of this institution calculated to produce other than grateful impressions upon benevolent minds. From the want of a more suitable place for accommodation of pauper lunatics, they are necessarily transferred into the Alms House; consequently, we have here presented to us the melancholy spectacle of cases of nearly all the varied forms of mental disease crowded in unclassified confusion.

Yet, most of the sufferers give some evidence that high mental and moral attributes still linger about them, fenestrating the gloom, "beams of Original light, of which the mind in its thickest darkness is never shorn" which seem to dwell even in "the dark grandeur of the soul" of the raving maniacs.

It is a well-known fact that the insane are often possessed of astonishing thought, that they are neither able properly to direct or control. It therefore becomes necessary that they should be deprived of facilities of escape, or opportunities of injuring themselves or others. Moreover, although medical skill is very important in the management of the peculiar disorder of their

nervous systems, it is no less necessary that, when confined, their apartment should be well-warmed, lighted and ventilated; their personal comforts studiously regarded and their morbidly sensitive minds gently checked and fortified by experienced, intelligent attendants, whose "consideration of convenience" should always be subservient to the probabilities of cure. The architectural unfitness of the building for the accommodation of lunatics need not be argued. It was not originally designed for their habitation and does not now afford the means of either secluding or classifying them, according to the intensity of peculiar features assumed by their maladies.

This report is made with the hope that you will agree as to the necessity and propriety of again urging upon the city and county the cruelty of that false economy which still refuses to take measures to place our insane poor where the architectural arrangements are so suited to the accommodation of lunatics, as to permit any advisable classification of the patients, while its internal arrangements afford humane, watchful and capable nurses, with such appropriate amusements and occupations for the insane as when aided by medical skill may prove promotive of their comfort and cure.

Heretofore, every practicable scheme to promote the comfort of these unfortunates—consistent with the purposes and arrangements of the house, as a general asylum for the poor, in which point of view we bear comparison with any other in the country—has been cheerfully adopted. Some of the insane are employed on the farms; such as are inoffensive and manifest no disposition to escape are allowed in good weather to exercise during the day in a small yard, designed for their exclusive use under the late arrangement of the grounds, suggested by Mr. McGuire, the Overseer.

Another class are furious, violent and ungovernable or such as take advantage of every chance to escape, are constantly in their small apartments, under the charge of temporary nurses, selected from the inmates of the House. There are two sorts of cells, those most recently erected being 8' by 12', those first constructed 10' by 12'. From these limited number, (14 cells being appropriated for female lunatics, and 12 to the male) and from the circumstance, that persons committed as vagrants are sent from the city and county to the Alms House, as a workhouse, it is impossible to afford each lunatic a separate room; two, three or more are confined together. The cells in the basement of the building now being erected as an Hospital for the colored women will somewhat enlarge their accommodation; still, they cannot be appropriately lodged—and their number is added to by frequent admissions.

Among them almost every form of insanity has a representation of its terrors; yet, how much less enervable must be the situation of the lunatics shut up in the Alms Houses and jails of the several counties of the state, or of such as remained chained in the hovels of poor relatives, who cannot be persuaded to entrust them to the charge of strangers! If insanity does not yield with more promptness than ordinary diseases, at least as large a proportion of recoveries will occur in recent cases under an appropriate medical, moral and intellectual

treatment as from any other acute diseases of equal severity something more than 90% of recent cases and from 14-25% of old cases having been cured. This encouraging truth, together with the fact that the chances of relief diminish in a geometrical ratio with the period of duration of the attack, show the importance of an early application of medical aid and cannot be too generally known.

The insane mind, not recognizing the justice or necessity of it, feels with morbid distinctness any form of personal restraint, and in the absence of occupation or amusement to relieve the irksomeness of confinement, it grows unhappy, discontented and restless, unless somehow its unfavorable influence is manifested by a functional disorder, sleep and appetite are banished, the illusions are aggravated, the idea of outrage, indignity and privation engrosses the mind, till lashed into fury; its ravings only cease with physical exhaustion.

This cannot now be termed a novel mode of treating insanity. It was introduced in France upwards of 50 years ago with triumphant success, superseding the coercive system, the standard remedies of which industriously applied "Have precipitated thousands of intellects from a condition of temporary danger to one of irretrievable ruin." When the functions of the brain and general nervous system are disordered resulting in irregularity of action and chronic delirium, can fetters, cheerless confinement, absence of occupation and increasing tumult recall harmonious action, and assist the recuperative energies of the mind to restore "An immortal native capacity of virtue, and the enjoyments of happiness?"

Every enlightened mind, every human heart will respond in the negative. Thus, why is our state so backward in providing a home for her destitute insane, where medical skill may unite with intelligent benevolence in a work of allaying the morbid excitement of the brain and regulating the disordered action of a chaotic intellect, recalling reason and reawakening all its natural sympathy?

To this class of her citizens, she is long in arrears!

Among the measures conducive to a favorable result, no one is more important than the principle of never allowing a patient to continue idle, if at all, in a condition of general health.

The mental revulsion induced by labor prevents the mortal illusions of the real or fancied suffering from wholly engrossing the attention, gardening, farming or mechanical operations, particularly if the patient has been accustomed to these, encourage cheerfulness and contentment, promoting at the same time refreshing sleep and appetite, the breath becomes improved and the mind invigorates. The anticipation of the benefits of labor, or the contemplation of its results, is also effective in awakening a feeling of satisfaction and self-respect, which greatly aids the patient in controlling any disposition to violence and indecency, and in banishing unpleasant impressions and feeling of irritation and degradation.

Of course, during the vesicular and nervous excitement frequently existing in the early stages, rest, seclusion and quiet will best allay diseased irritability of

body and mind, but as this disappears, exercise and employment viable to the condition of the patient, promotes convalescence and strengthens the mental and bodily powers, greatly aiding the medicinal treatment in removing the functional derangement in that portion of the physical system—the brain and nerves—which causes insanity.

We might also quote evidence to the beneficial influence of introducing Sabbath services within the confines of the asylum, judicially arranged and conducted; and that a large proportion of the patients are pleased if allowed to attend and behave with great propriety. But we have already far exceeded our prescribed limits, and must (assign) the subject to the charge of a more able and experienced advocate. It cannot be necessary to dwell longer upon the incharitableness of sending our maniac paupers into almshouses, where it is impractical to command the varied and nicely adjusted means best calculated to recall and reestablish physical and mental health. What inconceivable good might have resulted from the expenditure of a comparatively inconsequential sum years ago in the establishment of a state lunatic asylum—a large proportion of those who must now be a burden upon the community as long as they live might have been restored to their families to happiness and to usefulness?

When insanity was scarcely looked upon as a legitimate subject for curative treatment, almshouses were selected as suitable places for the safe confinement of these unfortunate subjects of it, but are they to be so regarded now? We trust not. Convinced that the want

of a well-endowed Pauper State Lunatic Asylum is a serious evil, the magnitude of which should be pressed upon the notice of our people and our government, we venture thus to entreat you earnestly to plead for its removal; feeling assured that the intelligent body of a people whose enterprise and determination to do all in their power to promote the true and permanent interests of their state and fellow citizens at large have induced the expenditures of millions in roads, canals and various other internal improvements, will probably respond to the cry for relief and advocate the desired provision for their destitute and insane if made to comprehend its necessity.

Such an institution assuming a high rank among our state enterprises would prove a blessing to a helpless and heretofore neglected class of our people and continue an admired monument of her benevolence.

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5. Bockoven, J.S.: Moral Treatment in American Psychiatry. J. New Ment. Dis. 124:167, 292, 1956.
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Presidential Meeting

On Nov. 29, 1978, a meeting was held at the Faculty Building on Cathedral St. in Baltimore for the Presidents of the Component and Specialty Societies.

Your President was invited to attend the meeting to speak about the Auxiliary and its activities; however, I learned more from listening than speaking. Approximately 16 Chairmen reported on the activities of their Committees. All of the problems concerning medicine were put forth, all of the work yet to be accomplished was explained. It was my regret that the spouses of the physicians attending could not have been there so they could understand how they can help medicine with the challenges that are coming. Important decisions are being made about the future of medicine and health care delivery, and most of us are not even aware of it.

A specific area of challenge is PSRO (Professional Standards Review Organization). Six years ago the PSRO program was mandated by the Congress of the United States. This organization gives physicians a mechanism to regulate the health industry through peer review at the local level. Physicians and their spouses must become aware of their responsibilities under the PSRO law. If they fail to respond, the alternative is stated in the **Congressional Record**, "The Government should not have to review medical determination unless the medical profession evidences an unwillingness to properly assume the task."

There are six PSROs in the Maryland area. They are Baltimore County, Montgomery County, Prince George's County, Southern Maryland, Eastern Shore and Central Maryland. They have been identifying problems in acute care hospitals and long-term care facilities. This is being done to improve care, to keep medicine costs down and to "Assure the American taxpayer that tax dollars are being spent for medically-necessary services."

Many dedicated physicians are giving their valuable time to run PSRO committees. They are eager to help other physicians attain a cost-effective, quality care practice.

We Auxiliary members should educate ourselves as to the impact of Public Law 93-641 on our spouse's profession. We must learn about HSAs, their projected health plans, the makeup of their boards and Health Services Cost Review Commissions in our own communities.



MRS. MARY STRAUSS (left) and MRS. KASSIE HERBERT at Auxiliary-AMA meeting at St. Louis, MO in June, 1978.



1978 MONTGOMERY COUNTY INSTALLATION LUNCHEON (left to right): MARTY PEREZ, MRS. HERBERT, ELSIE HARMON, NORMA FLAHERTY and MADRIAN SNYDER.



(From left to right): MRS. PEREZ, MRS. HERBERT, COLETTE CALILHANA, PAT EBERHARD and MRS. HARMON.

AUXILIARANS ON REVIEW (Photos courtesy the Auxiliary.)

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From the Auxiliary

"We are proud of all Auxiliary members, especially those whose pictures appeared on page 74 of the January, 1979 issue of the **Journal**. Those members are the current Presidents of the Component Auxiliaries. Unfortunately, we do not have a photograph of Mrs. Joseph Lanzi (Pat) of Cecil County."

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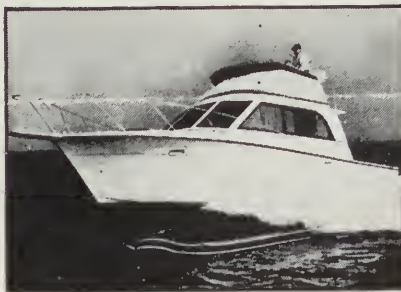
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Baltimore City Medical Society

CONRAD ACTON, MD, Editor

October General Meeting

The October, 1978 General Meeting took up business matters first. Our Nominating Committee's recommendations were well-received. A few nominations from the floor were made.

A report by the Peer Review Committee reviewed its activity of the past two years. Noting that their charge was to rehabilitate and educate rather than punish, they take pride in the small number of physicians, after being interviewed by the Committee, who need to be referred to higher authority for disciplinary action. Only two of the eight so reported out actually had to undergo discipline of one sort or another.

Dr. DeHoff Speaks

Baltimore City's Health Commissioner, John Burling DeHoff, MD, spoke of the importance of notifying the Health Department of reportable diseases. Baltimore physicians seem extremely forgetful, loth to get involved, or both, according to his data. Without adequate and prompt notification, though, Health Department strategies to deal with infectious disease problems to cure and prevent spread—and proper logistics for detection and treatment—will be inadequate. He reminded us that there are four categories of reportable conditions: 1) Communicable Disease of any kind; 2) Industrial Disease due to occupational exposure to harmful substances; 3) Bites or wounds from any animal, wild or tame and 4) Poisonings by food or chemical, intentional or accidental.

Dr. Stevens' Address

Diagnosis, Treatment and Surgical Aspects of Rheumatoid Arthritis was the topic of the scientific portion of the Meeting. Mary Betty Stevens, MD, Director of the Rheumatology Division at Baltimore's Good Samaritan Hospital, summarized various diagnostic aspects and pitfalls. With striking pictures and her rapid-fire delivery, she pointed out early and late manifestations of three main types. These were those: a) With joints involved only, b) Joints and another system involved and c) Joints with general systemic involvement. Humoral factors, X-ray variations and other laboratory findings were compared. Most tests are not specific. "Questions of diagnosis never end—they just change; one cannot outguess the future."

Dr. Klinefelter

Harry F. Klinefelter, MD, Associate Professor of Medicine at the Johns Hopkins Medical School, has his keystone of treatment in patient education. Arthritic patients **need** to be informed about the treatments used, what they are and what to expect from them. Modalities directed toward, in order of importance, should be for focal infection, nutrition, psychotherapy, physical therapy, medication and necessary surgery. He sorted medications into major categories: analgesia, anti-inflammatory and antirheumatic. He noted that spontaneous remissions are so frequent that it is difficult to determine whether any improvement is really due to the medication or would have occurred on its own.

Next, Dr. Hungerford. . .

David S. Hungerford, MD, Chief of Orthopedic Service at Good Samaritan Hospital, outlined the surgeon's role as not limited to operating, in rheumatoid diseases. It includes also splinting, protecting weight-bearing areas from pain and relieving deformity. Joint replacement is spectacular when it succeeds or fails. It should be used **only** to relieve pain, because the joint is destroyed after surgery. The loss of structural integrity cannot be regained. Most people have unrealistic expectations, especially about ensuing relief of pain. Patients must be fully aware of the negative aspects of joint replacement—mainly infection and cement failure. Bone cement is the technical weak link in the total replacement procedures. Other measures are being developed; one is joint resurfacing.

Board of Directors Meets

The Board of Directors tangled with a full agenda on Dec. 21, 1978. The Public Health Committee reported from its Jail Subcommittee that the Baltimore City Jail has been fully accredited by the AMA for its inmate health care facilities. The Subcommittee's members have worked very hard to bring this about. An award will be made formally at our Annual Meeting.

The Professional Education Committee recommended cooperation with Assist-Card International. They want to obtain names of multilingual physicians, especially those fluent in Spanish and/or French. Assist-Cards

are purchased by visitors coming to the US when they make their travel arrangements. Medical care is included as one of the benefits of the program. Medical insurance on Assist-Card holders is covered by Lloyds of London. A list of cooperating physicians is maintained at the offices for Assist-Card in Boston. When a traveller needs a physician, one in the appropriate specialty is contacted who can speak the traveller's language. The Directors approved a call for volunteers through our Newsletter.

Report from the Ad Hoc Committee on establishing a Medical Advisory Committee to the Ambulance Service of the Fire Department gave the outline of the Advisory Committee's present organization and charge. The Fire Department is to provide the administrative staff. Eight physicians have been proposed for selection by Baltimore's Mayor Schaefer. The Directors felt that these seem to be heavily-weighted toward emergency room specialists. There is one psychiatrist and none for alcoholism or drug abuse. Since alcoholics, addicts and psychotics constitute a very large portion of ambulance service passengers, it was felt by the Directors that the Advisory Committee should have experts in these fields as well.

New Study

The Health Care Delivery Committee proposes a study be made of primary health care delivery by private practitioners in Baltimore. They have found a doctoral student who proposes to do this. Already submitted

is a rough draft of **An Investigation of the Availability and Accessibility of Office-Based Primary Care in Baltimore City.** It begins: "Primary care should be considered the foundation of any comprehensive system of health care delivery. It can be defined as the level of entry into the system where basic health services are provided in a holistic fashion. The primary care practitioner is considered a generalist who does not limit his/her practice by type of condition or organ system. When assessing the distributional equity of any health service in any geographic area, two specific yet related issues must be considered. Firstly, services must be available as a prerequisite to their utilization. Secondly, a patient must experience unhampered access to that service if it is to be utilized."

The Directors supported this concept and agreed that they would allocate funds to sponsor it. ☐

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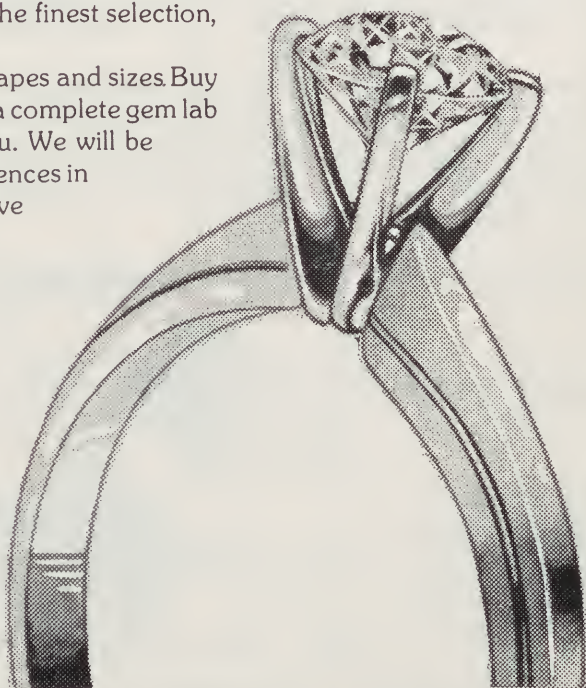
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Feb. 14, Albert J. Stunkard, MD talking on Obesity.

March 9, Anxiety, talk by Don Meichenbaum, PhD and Len Derogatis, PhD.

March 21, Psychotherapy and the New Psychiatry, talk by Jarl Dyrud, MD.

Apr. 5, Stages of Adult Development and Marital Stress, talk by Ellen Berman, MD.

George Washington University Dept. of Internal Medicine

All classes, talks, etc. held in Rm. 101, Ross Hall, GWU Sch. of Med. and Health Sci., 2300 I St., NW, Wash., DC. For details, call Dr. Arthur St. Andre at (202) 676-2821. All talks on Weds. evenings, 6:30-8:30.

Feb. 14, Liver Disease, talk by Hyman Zimmerman, MD., at 6:30 and another on **Hepatitis** at 7:30 by Jay Hoofnagle, MD.

Feb. 21, GI-Esophagus, small bowel malabsorption at 6:30 by David Fleischer, MD and **GI-large bowel, inflammatory bowel disease and vascular disease** at 7:30.

Feb. 28, Pulmonary Interstitial Lung Disease by Morgan Delaney, MD at 6:30 and **Pulmonary-Alveolar J Lung Disease** at 7:30 by Philip Witorsch, MD.

March 7, Pulmonary-Mass lesions, Pleural dx, mediastinal dx and vascular dx talk by Jerome Putnam, MD at 6:30 and **Pulmonary-Diag. Techniques, etc.** talk by Joel Taubin, MD at 7:30.

March 14, Infectious Disease-Fungi talk by Abe Macher, MD at 6:30 and on **Parasites** at 7:30 Martin Wolfe, MD.

March 21, Infectious Disease-Antibiotics, talk by Nigar Kirmani, MD and on **Bacteria** at 7:30 by Carmelita Tuazon, MD.

March 28, Viruses at 6:30 by Nathaniel Young, MD and at 7:30 **Dermatology** by Mervyn Elgart, MD.

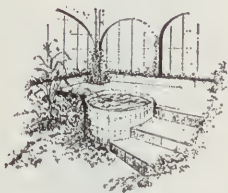
Apr. 4, Vascular Heart Disease at 6:30 by Alan Wasserman, MD and **Coronary Artery Disease** at 7:30 by Douglas Rosing, MD.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

Feb. 15-16, 1979 Cardipulmonary Nuc. Med. (Call above.)

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March 3, Problems in Adult Primary Care, at Balto. City Hospitals. Approved for 5½ cred. hrs. in AMA Cat. 1.

March 7-13, Update in Obstetrics, 1979, Caribe Hilton, San Juan, PR. For details, call (301) 955-5880.

March 12-16, Management of Obesity, for 32 cred. hrs. of AMA Cat. 1, Physician's Recog. Award.

March 15-17, J. Donald Woodruff Symposium on Gynecologic Oncology.

March 19-21, Spectrum of Developmental Disabilities in the Preschool Child: Issues in Detection and Trtmt.

March 22-23, Diag. and Trtmt. of Neoplastic Disorders.

March 26-30, Practical Cardiology for the Practicing Anesthesiologist.

March 29-30, College Mental Health Symposium, at the Homewood Campus in Balto. Approved for 15 cred. hrs. in AMA Cat. 1.

Apr. 2-7, Pediatric Trends, 1979.

Apr. 9-10, Psychiatric Update, 1979: Topics in Contemporary Psychiatry.

University of Maryland

March 1-Apr. 5, Selected Topics In Family Practice, Univ. of MD at Baltimore, Sch. of Med., Sophomore Lecture Hall, Howard Hall Tower. Meets every Thursday 5:15-7:45 P.M. For additional info., contact the Prog. of Cont. Educ. Univ. of MD Sch. of Med. at (301) 528-3956.

March 9-10, Gastroenterology for Primary Care Physicians, Cross Keys Inn, Columbia, MD. For additional info., contact the number above.

Other Maryland Meetings

March 7, Handling Patients Seeking Plastic Surgery, talk by Frederick C. Hansen, MD. For more data, call Ms. Karen Lane, CMA-AC, (301) 821-5222.

Feb. 21, Psychiatric Aspects of Cancer, talk by Leonard R. Derogatis, PhD at Taylor Manor Hosp. Ellicott City, MD. For details, call Dr. Frank J. Ayd, Jr. at (301) 465-3322.

Apr. 4, New Trends in OB/GYN, talk by Gerald Glowacki, MD. For details, call Ms. Karen Lane, CMA-AC, (301) 821-5222.

Apr. 27-28, Sexuality and the Cardiovascular Patients, Cross Keys Inn, Balto. 12 hrs. cred. AMA Phys. Recog. Award Cat. 1. For details, call Michaeline Silverstein, (301) 685-7074.

Miscellaneous Meetings

March 8-9, 15th Annual Postgrad. Course in Bone Rad., Williamsburg Conference Center, Williamsburg, VA. Fee: \$250. Contact: Ms. Erma Blanchard, Dept. of CME, VCU/MCV, Box 91, Richmond, VA 23298. Cat. 1, 21 hrs.

March 6-7, Diag. Imaging, Correlation of Ultrasound, Computed Body Tomography and Nuclear Med.: Hilton Hotel, Phila., PA. Contact: Peter Arger, MD, Hosp. of the Univ. of PA, 3400 Spruce St., Phila., PA 19104. Cat. 1, 13 hrs.

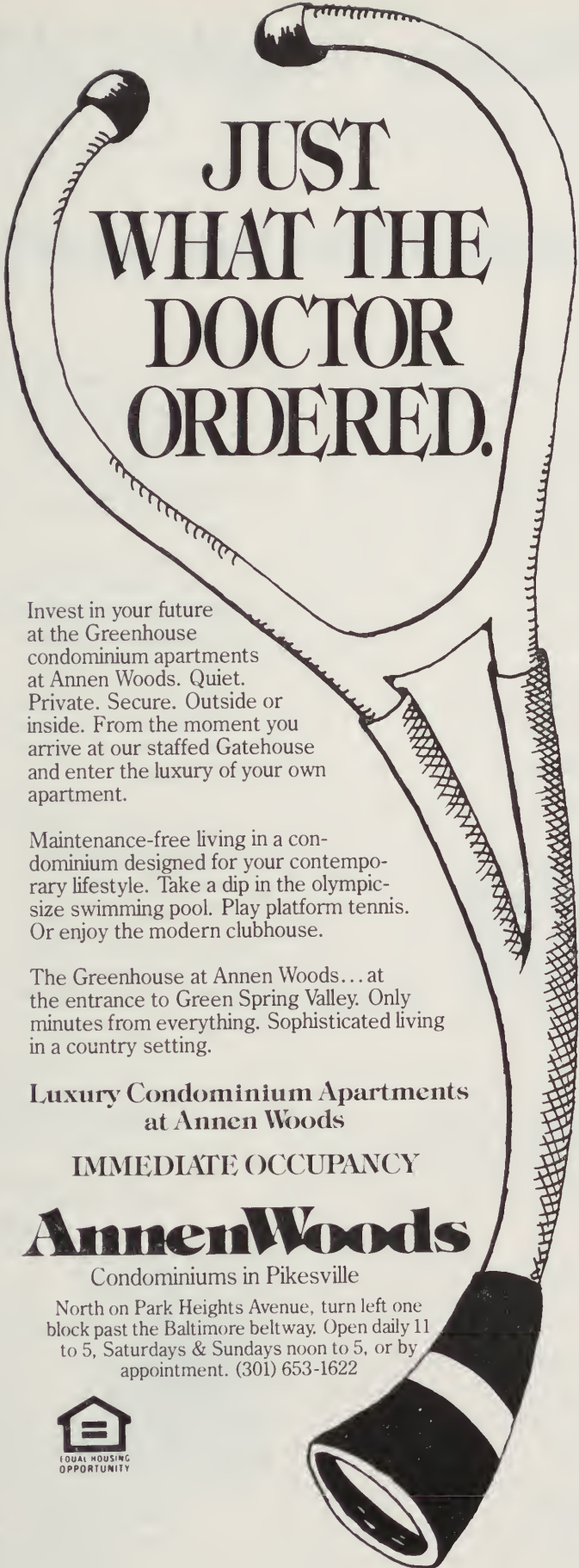
Apr. 3-8, 12th Natl. Sex Inst. of Amer. Assn. of Sex Educators, Counselors and Therapists, with theme of **Sexuality and the Life Cycle,** Mayflower Hotel, Wash., DC. For details, contact Ms. Rosalie Blasky at (202) 686-2523.

Apr. 5-7, Gastrointestinal Rad., Mt. Sinai Med. Ctr., New York, NY. Contact: Director, The Page and Wm. Black Postgrad. Sch. of Med., Mt. Sinai Sch. of Med., One Gustave L. Levy Pl., New York, NY 10029. Cat. 1, 16 hrs.

On-Going. . .

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Other Endowments. . .

The Library now has 14 endowments. The income from these has been adequate for the Library's journal subscriptions and new book purchases for some time, but inflation and a rapid increase in the cost of medical books and journals require that the Library either cut back its new book purchases and journal subscriptions or find additional sources of income. The average price of a one-year subscription to a US medical journal has increased from \$19.38 in 1968 to \$57.06 in 1978.

Success of the William Osler Associates program would greatly relieve the growing pressure on the Library's book and journal budget. The program offers an easy way for Faculty members to make significant contributions to continued maintenance of the Library (and contributions are tax-deductible!) so, please consider joining the Associates.

If the amount seems impractical at this time, you may wish to consider a bequest to the Associate program in your will. Your lawyer can advise you on how to do this.

Of course, gifts in lesser (or greater) amounts for the support and maintenance of the Faculty Library, or for the purchase of volumes to honor persons living or dead, continue to be welcome.

For additional information about the William Osler Associates program, or about contributions to the Faculty Library, please contact me.

JOSEPH E. JENSEN
Librarian



Gifts and Contributions

The Library gratefully acknowledges the receipt of the following gifts and contributions during October and November, 1978:

Samuel Morrison, MD

A collection of medical textbooks and medical instruments.

Frank J. Ayd, Jr., MD

An autographed copy of his recent book, **Mood Disorders, the World's Major Public Health Problem.**

Charles Lee Randol, MD

Four medical textbooks.

John H. Hirschfeld, MD

Twelve medical textbooks and a large number of medical periodicals.

Mrs. M. Bickel

Twenty-four medical textbooks.

Stanley R. Steinhach, MD

Twenty-six Audiocassette tapes.

George McLean, MD

Thirty medical yearbooks.

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Contact Mr. Joseph E. Jensen, Librarian.

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17 **Grant's Atlas of Anatomy.** 7th ed. Baltimore, Williams
.G 767a and Wilkins, 1978.
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- WG Davies, Hywel
200.3 **Understanding Cardiology.** Boston, Butterworth, 1978.
.D 255u
1978
- WG Linhart, Joseph W.
18 **Cardiovascular Disease.** Flushing, NY, Med. Examina-
.L 755c tion Pub. Co., 1977.
1977

Child Abuse

- WA Rodriguez, Alejandro
320 **Handbook of Child Abuse and Neglect.** Flushing, NY,
.R 694h Med. Examination Pub. Co., 1977.
1977

Delivery of Health Care

- W Plovnick, Mark S.
34.1 **Managing Health Care Delivery: a Training Program**
.P 731m **for Primary Care Physicians.** Cambridge, MA,
1977 Ballinger, 1977.

Diagnosis

- WB Spivak, Jerry L.
100 **Manual of Clinical Problems in Internal Medicine.**
.S 761m 2d ed. Boston, Little, Brown, 1978.
1978

Fractures

- WE Hartman, James Ted
175 **Fracture Management: a Practical Approach.** Phila.,
.H 333f PA, Lea and Febiger, 1978.
1978

Funeral Rites

- WA Consumer Reports
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.C 758f Consumers Union, 1977.
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Genetics

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50 **An Introduction to Medical Genetics.** 7th ed. New
.R 645i York, Oxford Univ. Press, 1978.
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350.8 **Help for the Hyperactive Child.** Boston, Houghton
.H 9 Mifflin, 1977.
.W 184h
1977

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- WM Spiegel, Herbert X.
415.3 **Trance and Treatment: Clinical Uses of Hypnosis.** New
.S 755t York, Basic Books, 1978.
1978

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504 CA, Lange Med. Pub., 1978.
.B 311
1978

Infant Nutrition

- WS Jelliffe, Derrick B.

125
.J 48h
1978

Human Milk in the Modern World. Oxford, Eng., Ox-
ford Univ. Press, 1978.

Intestinal Diseases

- WI Reimann, Hobart Ansteth
400 **Infectious and Parasitic Diseases of the Intestine.**
.R 363i Flushing, NY, Med. Examination Pub. Co., 1977.
1977

Labor

- WQ Friedman, Emanuel A.
300 **Labor: Clinical Evaluation and Management.** New
.F 911i York, Appleton-Century-Crofts, 1978.
1978

Nutrition

- QU Reuben, David
145 **Everything You Always Wanted to Know About**
.R 442e **Nutrition.** New York, Simon and Schuster, 1978.
1978

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- WT **Surgery of the Pancreas.** St. Louis, Mosby, 1978.
300
.S 961
1978

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- WO **Surgical Decision-Making.** Phila., PA, Saunders, 1978.
100.3
.S 961
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Articles Available Through the Med-Chi Library

"Field Dependence and Reaction Time in Senior Tennis Players (65 and Over)," by Rotella, R.J. and Bunker, L.K.: **Percept. Mot. Skills** 46(2):485-6, April, 1978.

"Tennis Elbow—A Radial Tunnel Syndrome?" by van Rossum, J. and others: **J. Bone Joint Surg. (Br.)** 60-B(2):197-8, May, 1978.

"Corticosteroid Injections in the Treatment of Tennis Elbow," by Day, B.H. and others: **Practitioner** 220(1317):459-62, March, 1978.

"Tennis Elbow," by Nagler, W.: **Am. Fam. Physician** 16(1):95-102, July, 1977.

"Tennis Elbow," by Nirschl, R.P.: **Primary Care** 4(2):367-82, June, 1977.

"Arm and Elbow Changes in Expert Tennis Players," by Priest, J.D. and others: **MN Med.** 60(5):399-404, June, 1977.

"Tennis and its Skin Problems," by Montgomery, R.M.: **Cutis.** 19(4):480-2, April, 1977.

"Experiences with the Garden Operation in Resistant Tennis Elbow," by Savastano, A.A. and Corvese, L.: **RI Med. J.** 60(2):78-9, 112, February, 1977.

"Thermography as a Diagnostic Aid in Tennis Elbow," by Shilo, R. and others: **Handchirurgie**, 8(2):101-3, 1976.

"Forces and Duration of Impact, and Grip Tightness During the Tennis Stroke," by Hatze, H.: **Med. Sci. Sports** 8(2):88-95, Summer, 1976.

"Tennis Shoulder," by Priest, J.D. and Nagel, D.A.: **Am. J. Sports Med.** 4(1):28-42, January-February, 1976.

"Tennis Elbow: The Syndrome and a Study of Average Players," by Priest, J.D.: **MN Med.** 59(6):367-71, June, 1976.

"Tennis Elbow and the Cervical Spine," by Gunn, C.C. and Milbrandt, W.E.: **Can. Med. Assn. J.**, 114(9):803-9, May 8, 1976.

"Racket Sports: An Ocular Hazard," by Vinger, P.F. and Tolpin, D.W.: **JAMA** 239(24):2575-7, June 16, 1978.

"Vision and Sports," by Getz, J.D.: **J. Am. Optom. Assn.** 49(4):385-8, April, 1978.

"Injuries in High School Sports," by Garrick, J.G. and Requa, R.K.: **Ped.** 61(3):465-9, March, 1978.

"Replication of Age and Physical Activity Effects on Reaction and Movement Time," by Spirouso, W.W. and Clifford, P.: **J. Gerontol.**, 33(1):26-30, January, 1978.

"Black Heel a Minor Hazard of Sport," by Wilkinson, D.S.: **Cutis.** 20(3):393-6, September, 1977.

"Fracture of the Hook of the Hamate in Athletes," by Stark, H.H. and others.: **J. Bone. Joint Surg.**, (Am) 59(5):575-82, July, 1977.

"Sports Identification Marks," by Spoor, H.J.: **Cutis.** 19(4):453-6, April, 1978.

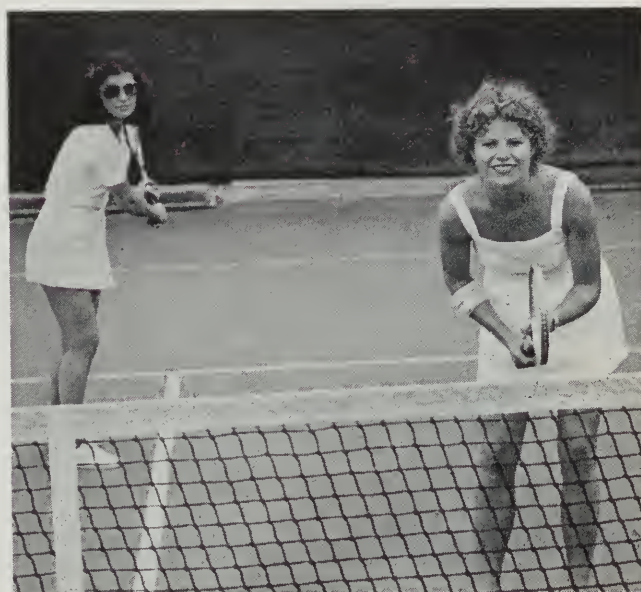
"Physical Activities: Teaming Up Patients and Programs," by Blocker, W.P., Jr. **Postgrad. Med.**, 60(2):56-61, August, 1976.

"How Different Sports Rate in Promoting Physical Fitness," by Conrad, C.C.: **Med. Times.**, 104(5):65-72, May, 1976.

"Rushing the Net and Retinal Detachment," by Seelenfreund, M.H. and Freilich, D.B.: **JAMA**, 235(25):2723-6, June 21, 1976.



THE COVER PHOTOGRAPHER: Paul Schlining, 32, is a part-time freelancer and graphic artist who is a regular contributor to the **Journal**.

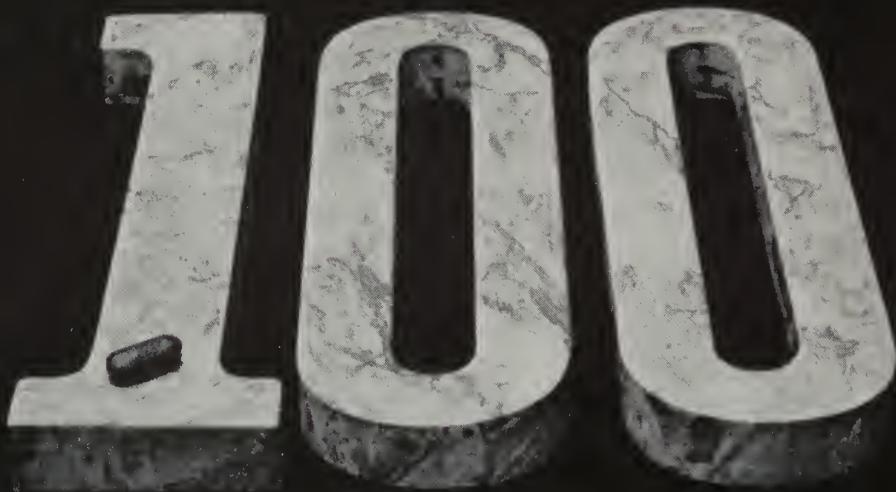


THE PLAYERS are SUZANNE PERRY, 29 (left), Nurse Recruiter for the Johns Hopkins Hospital and DENISE COURTNEY-KEYYON, MSW, 27, who is a Clinical Social Worker at Baltimore's North Charles General Hospital.

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Complete literature available on request from Professional Services Dept. PML.

Health in History

Was "Jack the Ripper" Heir to the British Throne? A New Book Says "Yes!"

By BLAINE TAYLOR

Contact Mr. Taylor, *Journal* Managing Editor, for reprint and other data c/o the *Journal*, 1211 Cathedral St., Balto., MD 21201.

Introduction

On the night of Sept. 30, 1888, London Police Constable Edward Watkins discovered a murdered prostitute lying in a pool of blood in a darkened square. 'She was lying on her back; at least what remained of her. She had been ripped apart, as he later related, 'like a pig in a market,' with her face smashed in and her entrails thrust in a heap around her neck. . . he screamed to the nightwatchman. . . ' For God's sake help me—there's a woman. She's been cut to pieces."¹

The occurrence was another in a series of six bizarre murders of British whores killed (all of them brutally disembowled) in London's sleazy East End between Aug. 31, 1888 - Feb. 13, 1891 (five were in 1888)² that have come down to history as the "Jack the Ripper" killings (so-called because of a note sent to a British news agency signed in that fashion).³

From the time the murders ended rather abruptly (without the public being convinced that Scotland Yard had ever truly apprehended the culprit) until 1970, the identity of the murderer was shrouded in mystery and doubt. In that year, however, a British physician — Thomas E. A. Stowell, CBE, MD, FRCS, DIH—published an article entitled "Jack the Ripper" — A Solution? in the British periodical, *The Criminologist* (available through the Med-Chi Library) in which he made sensational allusions that the killer was, in reality, none other than Prince Albert Victor Christian Edward (nicknamed "Eddy"), Duke of Clarence and Avondale, grandson of Queen Victoria, elder brother of King George V and son of King Edward VII (see "Bertie" — Britain's King Edward VII, *Journal*, September, 1978, p. 21), heir to the throne of Great Britain, who — historically, at least — is said to have died at age 28 on "Jan. 14, 1892, after a sudden attack of influenza."⁴

Author Frank Spiering has now followed-up Dr. Stowell's research with his own, and the result is an engaging little book (192 pages, 22 photographs and illustrations, plus a map of the murder sites) that flatly and unhesitatingly names the Prince as Jack and claims in addition that a) Queen Victoria's physician, Sir William Gull; the then-Prince of Wales, Edward; British Prime Minister Lord Salisbury and London Police Commissioner Sir Charles Warren all knew the

murderer's identity in 1888, b) they conspired to murder both the Prince and his homosexual tutor/lover, James Stephen in an attempt to cover-up and distort history and c) that Dr. Stowell himself may've been murdered (he died Nov. 8, 1970) by insidious government forces in reprisal for his *Criminologist* article.

Moreover, states Mr. Spiering — and of profound importance for the impact that health apparently has on history — "Prince Eddy, alias Jack the Ripper, shook the concept of 'the exaltation of Royalty' to its foundations. At that point, 'the Court,' headed by Lord Salisbury, stepped forward to reinforce the station of the Monarchy by ridding it of its greatest threat. In exchange for disposing of Eddy, 'the Court' has dictated to the Royal Family ever since." The author believes the heirs of the courtesan powers of the 1890s forced the abdication of King Edward VIII in 1936 (over Baltimore divorcee Wallis Simpson) and in the 1950s prevented Princess Margaret from marrying divorced Royal Air Force hero Peter Townshend. . . .⁵ "The power of England's rulers ended with Victoria, but more pertinently, it ended because of her grandson."⁶ This last view is somewhat at variance with my own research and findings, as reported in the *Journal*, however:

In terms of actually wielding true power, Edward VII was the last reigning British sovereign: his son and successor, George V, began the tradition of British rulers being completely subservient to Parliament and its political parties that has come down to us over the years and which exists today in the person of Queen Elizabeth II, King Edward's great granddaughter."⁷

(Edward ruled from 1901-10, and George V—his second son—from then until his death in 1936.)

Whether the discerning reader believes it or not, Spiering's book (also available in the Med-Chi Library, as well as at local bookstores) is a thrilling blend of dramatic detective work, fastpaced writing and historic facts, but before going further into a more detailed review of *Prince Jack*, let's pause a bit and take a brief look at Eddy's prior and rather sketchy place in the annals concerning this period in British history.

The Flawed Princeling

He is mentioned in all the major biographies of his illustrious father, King Edward VII. Born prematurely on Jan. 8, 1864,⁸ Eddy is described as rather backward

in Uncle of Europe: The Social and Diplomatic Life of Edward VII:

"Prince Eddy was a calamity for any parent to have to contemplate. Physically, he was almost as unattractive as the two elder sisters. Mentally, he was the dimmest of all the children, so dim and lethargic that his tutor, the Reverend Dalton, had to write him off as incapable of being educated. Morally, he was as dissolute as any of those Hanoverian great-great-uncles. Worse perhaps, for later generations were to indulge in the horrifying speculation that Jack the Ripper, that notorious, never-discovered murderer of London prostitutes in the 1880s, might have been none other than the Duke of Clarence. The mere fact that this fancy could even be floated demonstrates the unwholesome power of the legend he left behind him. It was perhaps a blessing for his parents, and certainly a blessing for the English crown, when this elder son of the Heir-Apparent died at Sandringham. . ."⁹

The puckish 1975 study — *Edward the Rake: An Unwholesome Biography of Edward VII* — says of Eddy:

"He combined extraordinary backwardness at work with still more extraordinary forwardness with women. Eddy had failed consistently at military academy and also got himself mixed up with women of low company. In this he never showed any of his father's tact or sense of discretion or decorum. Unlike his younger brother George—a stalwart lad and great favorite of his father's—Eddy was such a menace that the Prince was in despair. His irresponsibility and near idiocy were such that if news of them got out the future of the British Royal Family would look grim indeed. A rakish heir was bad enough; when he, in turn, possessed a son like Eddy, there could not be much hope for the continued popularity of monarchy in Britain. Bertie was keen to banish him—in true Victorian style—on a

long, absorbing tour of the colonies, but he was hardly in the position to play the heavy father. Interestingly enough, it was Alexandra who appeared more understanding. Perhaps she knew far less about what he had been up to, but thanks to her, Bertie agreed to let him stay in England with his regiment and then become engaged to young Princess May of Teck the following spring. As in his own case, 30 years before, it was felt that all that the young man needed was a wife. . ."¹⁰

"When his eldest son died, Bertie wept."¹¹

Still another Edwardian biographer—Christopher Hibbert—wrote in his 1976 portrait, *The Royal Victorians: King Edward VII, His Family and Friends*:

"Prince Eddy afforded his father no satisfaction. He 'sits listless and vacant,' Dalton reported, 'and. . .wastes as much time in doing nothing, as he ever wasted. This weakness of brain, this feebleness and lack of power to grasp almost anything put before him, is manifested. . .also in his hours of recreation and social intercourse.' After disembarking from the *Bacchante* for the last time, the boy, then aged 18, was sent to Lausanne to learn French, an undertaking totally beyond his powers. He was then entered at Trinity College, Cambridge, although in the opinion of J.K. Stephen, who had gone to Sandringham to help to cram him for the ordeal, he could not 'possibly derive much benefit' from attending university lectures, since he hardly knew 'the meaning of the words 'to read.' However, as a tribute to his birth rather than his intellect—which was not in the least stimulated by university studies and no doubt hampered by his being rather deaf—he was granted an honorary LLD, in 1888.

"He was not an unattractive young man. Edward Hamilton, who played bowls and billiards with him at Sandringham when he was 20, described him as 'a pleasing young fellow, natural and un-stuck-up.' Sir Lionel Cust thought that he had inherited much from his mother, to whom he was devoted, and that he might one day win the nation's heart as she had done. Prince Eddy confessed, however, to being rather afraid of his father, and aware that he was not quite up to what his father expected of him. He was extremely polite in his manner, modest, equable and deferential to his elders, particularly to his grandmother. In her turn, Queen Victoria regarded him with affection: he was a 'dear good simple boy,' dutiful and even steadily inclined; she loved him 'so dearly, she told Lady Downe,' an affection he returned so warmly. The Queen's secretary, Sir Henry Ponsonby, thought that, although his sentences were inclined to 'tail off' as though he had forgotten what he was going to say, Prince Eddy could talk quite sensibly when he chose and would be popular when he got 'more of his ease,' but he was certainly incapable of applying himself to anything for 'a length of time, and when he was bored, his perpetual fidgeting seemed like a nervous tic. He was, in fact, constitutionally incapable of concentration, except on whist, which he played quite well, and on polo, at which he was adept. As he grew older, he appeared only to be fully alive when indulging his strongly-developed sensuality. Despite a somewhat droopy cast of countenance, he was quite good looking and was undoubtedly attractive to women.

"Since he had evinced not the least enthusiasm for either the Navy or for Cambridge, it was now decided that Prince Eddy should go into the Army, but at first he showed no aptitude for that either. His instructor at Aldershot was 'quite astounded at his utter ignorance. When the Commander-in-Chief came down on a tour of inspection, he expressed the hope of seeing him perform 'some most elementary movement, but the Colonel 'begged him not to attempt it as the Prince had not an idea how to do it! And the (Commander-in-Chief) not wishing to expose him, let it alone!' His slowness was overlooked, however, and in time he did become moderately efficient. When he was 22, he was given a commission in the 10th Hussars. He did at least like the uniform, since he had always taken a great interest in clothes and, despite his lackadaisical demeanour, dressed him-



THE PRINCE (from *Prince Jack*.)

self with the utmost care. Always smart to the point of dandification, he was nicknamed 'Collar and Cuffs.'

"Prince Eddy returned from a trip to India in 1890 worn out and 'really quite ill' from the dissipated life he had been leading. Then, to compound his folly, he fell in love with Princess Helene d'Orleans, who was not only a Roman Catholic but daughter of the Comte de Paris, a pretender to the French throne. Before falling in love with her, Prince Eddy—or the Duke of Clarence and Avondale as he became in May, 1890—had wanted to marry Princess Alix of Hesse, but she would not consider him. He had then been asked to think about another cousin, Princess Margaret of Prussia, but he declined to consider her."¹²

"It was not, however, in Prince Eddy's nature to wait and see. Obligated to separate from Princess Helene, he found that, although 'quite wretched' for a time, absence did not make his heart grow fonder and that he was, after all, in love with Lady Sybil St. Clair Erskine, but this was not an acceptable match either, so the search continued for a suitable bride who might help to keep the dissipated bachelor out of further trouble. Where, though, his father asked, was 'a good sensible wife' with the necessary strength of character to be found?"¹³

"Fortunately, by this time, another possible bride had entered the lists, Princess May of Teck, a sensible, dutiful young woman whose virtues were held to outweigh the disadvantages of having a mother who was excessively slapdash and a bad-tempered father whose mind had been unbalanced by a stroke. So Princess Alexandra decided that Prince Eddy should marry Princess May and, in the meantime, remain with his regiment as she had wanted. The next day she sailed for Denmark. . .

"In her absence, negotiations for Prince Eddy's marriage progressed smoothly. Amenable as always, he complaisantly accepted Princess May, proposed to her at a house-party at Luton Hoo and was accepted. The wedding was fixed for Feb. 27, 1892, a few weeks after the bridegroom's 28th birthday.

"His father expressed the greatest satisfaction and relief. . . The Prince's contentment did not, however, last long. Soon after Christmas, Prince Eddy, pale and shivering, returned from a day's shooting with his father at Sandringham and went to bed with a bad headache that presaged the onset of influenza. He came downstairs on his birthday to look at his presents, but felt too ill to stay long and went back to bed. His mother watched him climb the stairs, and never afterwards forgot the way he turned to give her 'his friendly nod.' Soon afterwards, seriously ill with pneumonia, he became delirious, and on Jan. 13th, his mother, who had sat by his bedside all night, woke her husband to tell him that she believed their son was dying.

"The Prince would not at first believe it. Taking comfort from the specialist who felt that there was still some hope, he constantly appeared at the door of the sickroom, looking anxiously in upon his son, who never stopped talking, but with great difficulty and effort,' as his mother said, 'and with that terrible rattle in his throat.' From time to time, it seemed that the Prince's hope might be justified; subcutaneous injections of ether and strychnine brought the patient momentarily round, but then he relapsed again. Princess Alexandra wiped the sweat from his face and neck, and the nurses placed packs of ice on his forehead. At last he cried out, 'Something too awful has happened. My darling brother George is dead.' He then asked, 'Who is that? Who is that? Who is that?' murmuring the question repeatedly until he died.

"The Prince of Wales was grief-stricken, quite 'broken down,' as his mother said. . .

"For years, the hat which Prince Eddy had been wearing when he went out shooting for the last time, and which he had waved to his mother as, glancing back, he had caught sight of her at a window, was kept hanging on a hook in her bedroom. And for years, too, his own room was kept exactly as it had been when he was alive to use it, his tube of toothpaste being preserved as he had left it, the soap in the washbasin being replaced when it mouldered, a Union Jack draped over the bed, and his uniforms displayed behind the glass door of a wardrobe.

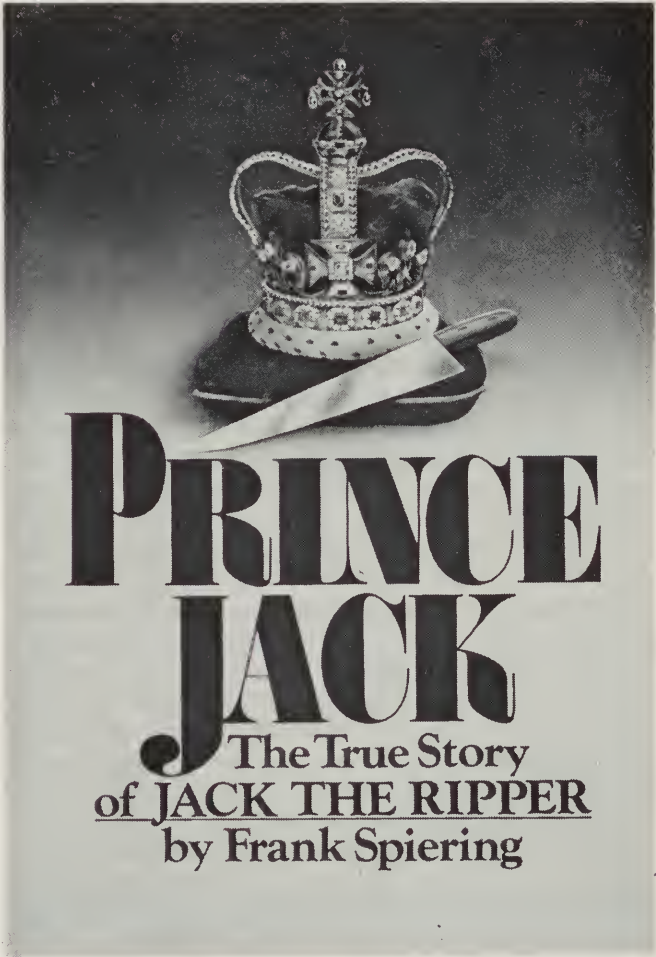
"Gladly would I have given my life for his,' the Prince told

his mother, 'as I put no value on mine. . . Such a tragedy has never before occurred in the annals of our family.' Yet he knew in his heart that Prince Eddy had been hopelessly ill-qualified for the position for which his birth had destined him, and it was of inestimable comfort to his father that his new heir, Prince George, who was quite content to marry Princess May, seemed, on the contrary, suited in every way to kingship."¹⁴

Finally, the latest major study on Britain's Royal Family — Robert Lacey's 1977 book, *Majesty: Elizabeth II and the House of Windsor*, adds these comments:

"Eddy was a weak youth, notorious for his sexual adventuring. (It has traditionally been supposed that Prince Eddy, the Duke of Clarence, was homosexual. His name was implicated in the scandal attending the discovery of a male brothel operating in Cleveland St. in the West End of London in 1889, but the release of the long-embargoed papers on the case which involved several eminent figures in late Victorian society appears to indicate that the Prince only visited the brothel once in the expectation of poses plastiques—Victorian for striptease—and was disappointed. H. Montgomery Hyde's recent research into these and related papers does indicate, however, that the Prince was treated at least once for gonorrhoeal infection, though there is no evidence of this in the Queen's Archive.) Quite resolute, and definitely unflappable, the future Queen Mary, then known as Princess May of Teck, seemed the best woman to cope with him, and when the Prince died of pneumonia a few months after they had got engaged, it had seemed logical that Princess May should be recalled to Eddy's younger brother, George; the next in line for the throne. . .¹⁵

"Prince Eddy. . . was an aristocratic delinquent who, had he lived, might well have got into trouble as a result of his sexual adventuring."¹⁶



Spiering's Jack

Author Spiering makes no bones about it—Eddy was Jack and committed all the murders attributed to the near-fabled knifer (a practice of killing, he says, the young Prince viewed first-hand at a London slaughterhouse.)¹⁷ Numerous people—including London Bobbies—actually saw the suspect (he was almost caught in the act at least once) on the streets prior to the murders (carrying a rolled-up newspaper that concealed the butcher's knife used in the slayings, the author feels) with later physical descriptions rendered to detectives: “. . . About 5'8" tall, with a pale complexion, dark hair and a slight moustache curled up at each end) perfectly fitted Eddy”¹⁸ “. . . about 30 years old. . . dressed in something like a Navy serge coat, with a deerstalker's cap. . . the killer wore a red neckerchief. . .”¹⁹

A Sherlockian Connection?

As a Sherlock Holmes adventure fan, one aspect of the Ripper's description—namely the presence of the deerstalker cap—fascinates me, but the possible link was apparently missed by Mr. Spiering. After all, the Holmes pieces began being published in 1885-86 (see *Sherlock Holmes, MD* in the July, 1978 *Journal* on p. 33)²⁰ and, as all true Holmesians know, the central character wore a deerstalker cap. Eddy's father, the Prince of Wales, was a well-known fan of Dr. Doyle's writings,²¹ and isn't it possible that his son was, also? Did he select the deerstalker cap for this reason? Ironically, perhaps, Nigel Morland's Introduction to *Prince Jack* states that Conan Doyle told him that the Ripper was “‘Somewhere in the upper stratum,’ but he would never enlarge on that statement.”²² Doyle was good at keeping official secrets, it should be noted, but the notorious woman-chasing Prince of Wales did appear as a fictional character in at least one Sherlockian tale — *The Adventure of the Illustrious Client*.²³

Eddy's Anti-Semitism

As the police on the beat searched frantically for the unknown killer, suspicion naturally turned onto people who used knives—such as butchers—and the London press (prior to discovering the moniker of Jack the Ripper) christened him “leather apron,”²⁴ since butchers wore these. One person arrested as a suspect was a Polish Jewish shoemaker who was found to have five sharp, long-handled knives in his rooms.²⁵ The news of his arrest led to a burst of public anti-Semitism with mobs accosting innocent Jews on the streets; one, a slaughterhouse workman, was stoned, “Lost his reason and had to be committed to an asylum.”²⁶ In order to distract attention away from himself, Eddy, so author Spiering believes, pandered to this always-latent strain of Victorian anti-Semitism by scrawling a message in chalk on a wall near the scene of one of the grisly murders: “The Juwes (sic) are not the men that will be blamed for nothing.”²⁷

They were blameless, however, the writer asserts, as Jack's true identity had been discovered as early as Sept. 30, 1888—the night of murders number three and four (with two more yet to come)—by London Police

Commissioner Sir Charles Warren, who, acting on a tip from a suspicious officer who'd seen Eddy returning home at 5 AM after one murder, decided to track the Prince himself. “His one course of action was to protect the Royal Family at any cost. It was his duty to the Queen that no one should suspect her grandson,” Spiering writes.²⁸

He further states that Sir Charles immediately instituted an official—though highly-secret—government cover-up by controlling the inquests held in the various murders, replacing coroners who asked too many questions²⁹ and by assigning less policemen to cases rather than more (as ordered by the Queen.)

The cover-up was aided, surprisingly enough claims Spiering, by the Queen's own private physician—Sir William Gull—who the author says, was “One of the great medical pioneers in the use of static electricity to treat nervous diseases.”³⁰

Enter Dr. Gull

Ironically, it was Queen Victoria herself who sent her grandson to see Sir William, who had helped save her son the Prince of Wales from death by typhoid in 1871. In October, 1888—after the first four murders had already been committed, Spiering says, the Queen had Eddy for lunch, noticed he was pale and trembling and so ordered him to see Dr. Gull, which he dutifully did. Upon examination, Eddy's “. . . Appearance revealed symptoms of extreme dementia. . . From the young man's complaint of headaches and the evidence of chronic suppuration about the ear, Gull immediately recognized that he was suffering from syphilitic cachexia.”³¹ (The Prince had contracted syphilis at age 18—in 1882—in Australia.³² As Eddy once told his homosexual lover/tutor, James Stephen (who'd also been treated by Dr. Gull—for a head injury), he'd gotten “sores” from a prostitute.³³

Intrigued by this Royal patient who was in a direct line to someday succeed to the English throne (his father, as King Edward VII, died in 1910, when Eddy would've been only 46), Dr. Gull decided to try what was then considered a rather novel mode of treatment—hypnosis. He was shocked and horrified to discover that his Royal patient was actually the dreaded Jack the Ripper.

“Eddy told him first about James, then about the anger he felt toward his father. Finally, his eyes became like glass as he recalled another image, one that filled Gull with alarm. It was ‘the knife’ he referred to and the woman in the darkness.

“Gull watched in horror as Eddy showed him how he slit the woman's throat. The phantom knife descended with a sudden thrust down.

“‘Why?’ Gull asked.

“But Eddy could only repeat what he had told him. He repeated it as if something inside him were stuck on that image. Finally Gull made him stop. There was no point in going on.

“Sir William Gull had discovered the ‘latent cause’ for Eddy's demented state. The syphilis had thrust him into fits of fantastic rage. Violence was the outpouring of his pain.

“But in Eddy's case, it was not simply fantasy. He had re-enacted the obsessions that he felt. The madness which had overtaken his being was a perpetual state of delirium. He was not mentally responsible, yet the acts had been committed.”³⁴

(Spiering speculates that “. . . a dark madness led him into the streets of Whitechapel to annihilate women he did not know. Except to him, they represented *all* women, as his desire for satisfaction was convoluted into an intense passion to dissect them.”³⁵

Faced with the overwhelming enormity of his terrific discovery, Dr. Gull contacted Sir Charles, only to learn that he, too, had found our Eddy's gruesome pastime.

Jack Confined

Sir Charles told the doctor that the astonishing revelation had already been passed along to Her Majesty's Prime Minister, Lord Salisbury (but never to the Queen herself.) The Police Commissioner and the Court Physician decided to commit Eddy to the House of Rest Sanitarium at Balham, a small village outside London.³⁶ The Prince of Wales was informed by “His own physician, Sir Henry Acland, that his son was suffering from syphilis.”³⁷

Dr. Gull became worried about his patient's deteriorating condition:

“He noted that since his arrival, the Prince did not seem to be awake most of the time. In addition, he was gradually becoming incoherent in his speech, which Gull attributed to aphasia accompanying his condition. This partial loss of power of articulate speech was not due to a defect in the peripheral organs, but to a disorder in one or more of the cerebral centers.

“Within the second week of Eddy's confinement, reports began reaching Gull of a marked change in his disposition. According to the attendants assigned to his case, the Prince, with increasing regularity, was becoming wildly delirious and extremely violent in his actions.

“This state was often common in syphilitic patients, but once again the ‘latent cause’ theory presented itself to Gull. The syphilitic condition could be controlled, but not the inner torment, the madness which had driven this young man to acts of premeditated butchery. This fact would always lie heavily upon the conscience of his protectors, who were now so desperately trying to protect themselves.

“Gull, at 72, was a sick man. His medical career had been radiant with accomplishment, and now he was faced with having to conspire in an act so ignoble and repugnant that it haunted him. To hold an heir to the British throne captive in order to conceal the monstrous deeds for which he was responsible was taking a terrible toll, and the worst was yet to come.”³⁸

During the early morning hours of Nov. 7-8, 1888, in a fit of rage, Eddy escaped.³⁹ The drugs he'd been given had caused “Shooting pains throughout his legs and arms”⁴⁰ and he believed his father was responsible for his confinement, and also felt his tormentors meant to murder him.⁴¹ Nov. 9, 1888 was the Prince of Wales' 47th birthday, and Spiering believes that was why Eddy—as Jack the Ripper—chose that date for the fifth murder, as a sort of macabre birthday present.⁴²

He was apprehended and returned to the sanitarium. In 1889, he was allowed—under guard—to make a State tour of Britain's Indian Empire, and during this time strangely enough, there were no Ripper murders. It was thought, perhaps, that the young Prince could be secretly and quietly rehabilitated, but Dr. Gull, who died of a stroke in 1890,⁴³ knew better. On Feb. 13,

1891, there occurred the sixth and final Ripper murder. Eddy was back in London.⁴⁴

Doom for the Ripper

“On Nov. 21, 1891, James Stephen was committed, by the powers who ruled England, to the lunatic ward of St. Andrew's Hospital, Northampton,”⁴⁵ author Spiering states. Eddy had early-on revealed himself to Stephen by bringing—wrapped up—one of his mutilated victim's organs. Stephen was his closest friend. Twenty days after Eddy's demise, says Spiering, Stephen “Had been starved to death.”⁴⁶

And what of the actual fate of “Prince Jack” himself? “In place of the regular administrations of iodide of potassium, Eddy most probably was given daily injections of morphine. . . the dosages were steadily increased until the sleep condition became permanent,”⁴⁷ i.e., the **British Government murdered the eventual Heir to its Throne.**

“Shortly after the deaths of Eddy and his lover. . . in 1892, the official Jack the Ripper File was sealed by the Metropolitan Police. . . and designated to be hidden away for the legal 100-year period. The file's cover was marked with the profoundest verification of the murderer's identity: Closed until 1992.”⁴⁸

A Few Bizarre Aspects of the Case

*At the inquest of victim Annie Chapman, it was revealed to a horrified audience that her uterus was missing; this was the wrapped item that Eddy proudly presented to James Stephen, Spiering attests.⁴⁹

*One Ripper note to the police contained one of the victim's left kidneys', and stated, “ ‘Tother piece I fried and ate it; was very nice.”⁵⁰ Spiering claims that Stephen was, in reality, the author of **all** the Ripper letters—not Eddy.)

*“A police official had now ordered that the eyes of Annie Chapman be photographed in the belief that the retinas might contain the image of her killer. . . an assassin having been convicted in France on the strength of eyeball photography. It was not a new idea, but the police were obviously desperate to try anything.”⁵¹

*A doctor at “St. George's Hospital, Hyde Park Corner,”⁵² confessed to being Jack, refused to give his name and three weeks later his dead body was fished out of London's Thames River.

Some Dissent

Generally speaking, **Prince Jack** is an exciting, well-written book in which the author makes a strong case for his theory. As source material, he claims to have had access to a copy of Sir William Gull's notes and to have seen the police file on Jack; however, regarding the last, he says “I was not surprised to find that the contents have been gutted.”⁵³ For my part, I feel that—although such scanty evidence makes for an interesting story—it is a somewhat slender thread.

Factually, I was able to discover only one outright error. On page 34, the author gives the date of August, 1888 as the start of the ill-starred reign of German

Kaiser Wilhelm II; in actuality, it began in June, upon the death of his father, Kaiser Frederick III.

Finally, there is a question in my mind that the author fails to answer. The last known Ripper murder occurred on Feb. 13, 1891, yet Eddy survived—at least historically—until Jan. 14, 1892, almost a full year later. Why the delay on the part of the Government in murdering the Prince? Rather incongruously placed toward the end of the book is this statement: "There was no further question in his mind that Eddy's identity could be hidden. With a ruthlessness that he had never before exercised, Salisbury moved to end the whole nasty business once and for all."⁵⁴ A year's wait hardly seems to me to be expeditious, especially in this case.

Unlike author Spiering, however, I prefer not to make any flat statements pro or con the theory of the Ripper's true identity—that I leave to the reader's own judgment.

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Acknowledgment

The author thanks Mrs. Mildred Chronister for secretarial services.

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The Role of Podiatry

By HARRY F. KLINEFELTER, MD AND NEIL M. SCHEFFLER, DPM, AACFAS

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Abstract

A great deal of misunderstanding and controversy exists regarding the position and role of podiatry in the medical community. A review of the history of podiatry, the education of podiatrists and the care podiatrists render patients should assist the physician in evaluating the role podiatry can assume in the comprehensive treatment of his patient.

Foot health has been a concern of mankind since at least 372 BC when the Greek Theophrastus mentioned corns. Hikesios of Smyrna (circa 60 AD) prepared a plaster for the treatment of corns. In the 4th Century, the Guild of Barber-Surgeons in Northern Europe treated feet as well as applied leeches, pulled teeth and practiced bloodletting. Medicine, dentistry and podiatry eventually evolved from these ancient roots forming their own divisions of medical practice.¹

Although, in the United States, podiatrist is the term now used for foot specialists, the term chiropodist had been in widespread use until recent years. It is unclear whether chiropody was coined from the Greek "cheirourgos" meaning surgeon, and "pedes" meaning foot, hence "surgeon of the foot," or from the Greek "cheir" for hand, since chiropodists, even in the US, treated both hands and feet.

The term was officially changed to podiatry to remove the treatment of hands from the scope of podiatry and to eliminate the confusion between the unrelated terms "chiropodist" and "chiropactor."

Due to the very short history of the profession and to the small numbers of its members, there is

some confusion about podiatry's image.

Itinerant "corn cutters" roamed the country as late as 1900 soliciting business from door-to-door. Unfortunately, the memories of these crude beginnings may still linger and affect the image of podiatry.¹ The profession has developed quite rapidly, especially if one realizes that this country's first licensing act was passed in New York in 1905, and it was only 68 years ago, in 1911, that the first American School of Chiropody was established in New York.²

There are only five podiatry colleges in the US. They are located in New York, Chicago, Philadelphia, San Francisco and Cleveland. Approximately 530 students will be graduating from podiatry school this year. There are about 8,000 podiatrists in the US, and since most of them practice in states where there are schools, there is a shortage of podiatrists in many parts of the country. The Department of Health, Education and Welfare has designated these "shortage areas" (many areas of Maryland, for example, have been so designated) and has provided incentives to graduating podiatrists to open their practices in these areas. Lack of exposure to the general medical community has kept the image of podiatry from keeping pace with the sweeping changes in the education of its members.

It has repeatedly come to the authors' attention that many physicians have little knowledge of what podiatrists can do and what their educational backgrounds are. A vivid example was reported by Richard N. Podell, MD in the *New England Journal of Medicine*:

"Millions of Americans visit a podiatrist each year. Millions more have problems with their feet. Nevertheless, many Americans and

their physicians have little idea of who the podiatrist is and what he does. The author (RP) had the following conversation with a resident in orthopedics and his attending orthopedic surgeon:

RP: What do you think of podiatrists doing surgery on the foot?

Resident: If they did, they'd be put in jail!

RP: Why?

Resident: It's illegal for a podiatrist to operate.

RP: Are you sure?

Attending: No, it's not illegal, but it should be. You wouldn't want someone with only a couple of years' education operating on your foot.

RP: You mean they have only two or three years of education after high school?

Attending: Yes.

RP: Are you sure?

Attending: Yes."¹

Contrary to this attending's impressions, applicants to podiatry school have the same undergraduate requirements as those applying to medical and dental schools. As is true of those who are accepted to medical school, most who have been accepted to podiatry school have earned at least undergraduate degrees and some have earned graduate degrees. Applicants to podiatry schools take the same entrance exam (MCAT) as do those applying to medical school.

Podiatry students attend podiatry school for four years—the first two concentrate on the basic sciences—gross anatomy, physiology, pathology, histology, biochemistry, neuroanatomy, pharmacology, etc. The same texts, and in many cases, the same instructors who teach in neighboring medical schools, are utilized.

In the second two years, podiatry

schools emphasize the clinical aspects of treating foot problems. These years include intensive study in diabetes, peripheral vascular disease, geriatrics and podopediatrics. Students treat patients in clinics, do hospital rotation and externships, assist in surgery and rotate through many services applicable to their field such as dermatology, orthopedics, radiology, pediatrics, anesthesiology, emergency room, etc.

Following graduation, with a degree of DPM (Doctor of Podiatric Medicine) specialty residency programs are available, the most common being in podiatric surgery. Continuing education is required in Maryland and many other states for renewal of licensure. This represents the awareness of the need for maintaining and increasing the professional knowledge and skills of the practicing podiatrist.²

Podiatrists are accepted members of the medical community and have direct patient responsibility and the legal right to make and act upon their own independent medical judgment. This is shared only with the medical doctor, the osteopathic physician and the dentist.³ The Joint Commission on the Accreditation of Hospital guidelines⁴ permits the granting of privileges to podiatrists. Many hospitals recognize the need for comprehensive patient care and grant surgical privileges to podiatrists, also.

In Maryland, the practice of podiatry is defined as "The diagnosis and the surgical, medical or mechanical treatment of all ailments of the human foot, except arthrodesis of two or more tarsal bones, complete tarsal osteotomy, amputation of a toe or toes and administration of an anesthetic, other than local."⁵ The podiatrist can—and does—treat such disorders as bunions, hammertoes, heel spurs, fractures, skin and nail conditions, infections, local complications of diabetes and peripheral vascular disease (e.g., ulcerations), mechanical problems of the foot, athletic injuries, pediatric foot deformities and local manifestations of the arthritides, as well as other conditions. The signs and symptoms of

many systemic diseases may first become manifest in the foot. The podiatric examination often reveals systemic disease and the patient is referred for appropriate medical treatment. Examples of these diseases are numerous. One of the authors (NS) has referred patients for treatment of previously-undiagnosed dermato-fibrosarcoma, hypertension, psoriasis, diabetes mellitus, alcoholism, arterial stenosis and occlusion, tuberous sclerosis, congestive heart failure, gonococcal arthritis, other arthritides, scleroderma and many other diseases.

Physicians may make excellent use of podiatrists. Vascular surgeons and internists have long recognized the need for prophylactic care for ischemic and diabetic feet. One of the authors (HK), whose primary interest is rheumatology, has often utilized podiatrists for the treatment of the local painful manifestations of joint disease. This care may be as simple as the fabrication of a pad or orthotic device, or the recommendation of foot gear to accommodate deformed joints. The treatment, however, may involve surgical removal of all metatarsal phalangeal joints with the insertion of plastic joint replacements coupled with tendon surgery and phalangeal arthrodesis or arthroplasty.

The podiatrist, with his scope of practice limited, finds keeping pace with all advances in treatment of foot disorders within his grasp. Other physicians who treat feet as well as the rest of the body often find that rapid changes in these many areas are difficult, if not impossible, to cover adequately. Often, the foot is neglected. Dr. Sherman Coleman, the President of the American Orthopedic Association, has stated that "...there no longer is the opportunity to remain competent in all fields of orthopedics." He also stated that he stopped doing many things because he doesn't feel qualified—either because he doesn't do enough off them to maintain skill, or because he doesn't have enough time to keep up with the writings on them or because he can't learn all the new techniques. He stated that any doctor

who performs specialized surgery only intermittently should not continue to perform such procedures. He further stated, "This is a very sensitive subject, but we can't keep it quiet. It must be discussed. People deserve the best available." Dr. Coleman also stated that he believes that "it is better to do a few things well than everything not so well."

At present, 16 hospitals in Maryland have podiatrists on staff. Privileges include the full scope of podiatric medicine including surgery. Admission to the hospital is made in conjunction with a physician member of the medical staff. The podiatrist is responsible for the foot problems of the patient during the hospital stay while the physician cares for the patient's general medical problems. This team concept has worked out very well.

In conclusion, podiatrists and physicians should realize that only through a mutual exchange of ideas and techniques, through better communication and through referrals between the professions, can patients receive the best medical care. The American Medical Association and the American Podiatry Association have realized this and the AMA has created a Board of Trustees Liaison Committee on Podiatry in order to enhance understanding between the medical and podiatric professions. The committee is composed of representatives from the AMA, APA, American Hospital Association, American College of Surgeons and American Academy of Orthopedic Surgeons. It is hoped that this idea will filter down through the State, Regional and local medical societies so that local representatives of both groups can enhance understanding of the role of podiatry in our community.

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Carcinoma Arising in a Villous Adenoma in a 19-Year-Old Male with Review of the Literature

By ATEF AL-SIBAI, MD; VICTOR ALBITES, MD; KONSTANTINOS DRITSAS, MD,
FACS AND NEIL NOVIN, MD, FACS

All the above physicians are Baltimore-based. For reprint information, write Dr. Novin at South Baltimore General Hospital, 3001 S. Hanover St., Balto., MD 21230.

The case of a villous adenoma with focal malignant degeneration in a 19-year-old-black male is reported. Clinically, it presented with rectal bleeding. Subsequent resection of the lesion revealed an adenocarcinoma with invasion to a mesenteric lymph node and pericolic fat. Review of the literature establishes the previous youngest age of incidence to be 27. The occurrence of this entity in a 19-year-old black male coupled with the apparent aggressiveness of the lesion prompted us to report this unique case.

Case Presentation

A 19-year-old black male presented to the Emergency Room on May 18, 1976 for the first time with the chief complaint of rectal bleeding of one day's duration. Past history revealed that he had been having bloody stools for approximately one month prior to the acute episode necessitating the Emergency Room visit. There was no history of diarrhea, changes in bowel habits and no weight loss.

Physical examination revealed a well-developed, healthy male in no distress with stable vital signs. On rectal examination, there was a mass noted on the posterior wall of the rectum, soft, slightly irregular, approximately six-seven cm. from the anal verge. The superior edge could not be palpated by the examining finger. The hematocrit on admission was 42%, which fell over the subsequent two days to 27% and which required replacement transfusion. Proctosigmoidoscopy revealed a whitish papillary sessile lesion on the posterior rectal wall with its lower border seven cm. from the anus. It bled easily to touch and extended 11 cm. superiorly to the rectosigmoid junction. Forceps biopsy

was obtained at the time of proctosigmoidoscopy which showed fragments of villous adenoma was a small focus of frank malignant degeneration. Because of the superficiality of the biopsy, the degree of infiltration could not be determined. (See Figure 1.)

UGI Series was normal. BE: large irregular abnormality in the proximal portion of the rectum which appears to be consistent with large polyp. Colonoscopy showed no other lesion in the colon. Re-biopsy at the time of colonoscopy showed benign villous adenoma.

Due to the reluctance of the patient to accept an abdominal perineal resection, the lack of specific information regarding the degree of invasion and the age of the patient, the decision was made to do a trans anal excisional biopsy under general anesthesia. This was performed June 2, 1976, and at that time a small polyp was noted superior to the primary lesion and this was excised also, and revealed an adenomatous polyp. The pathology report from the primary lesion indicated a villous adenoma with an area of infiltrating poorly differentiated adenocarcinoma. It was further noted that the fragment of intestinal muscular wall showed tumor infiltration. (See Figure 2.)

Metastatic workup revealed a normal liver scan, brain scan and bone scan. His CEA was greater than 20 ng./ml. With the information provided by the excisional biopsy, an abdominal perineal resection was recommended, accepted by the patient and done on June 14, 1976. The pathology report on this specimen showed a resected sigmoid and anus showing moderately well-differentiated adenocarcinoma with extension to the pericolic fat and lymph nodes. A mesenteric lymph node showed poorly-differentiated adenocarcinoma replacing the normal lymphoid stroma to a large extent. (See Figure 3) Duke C2.

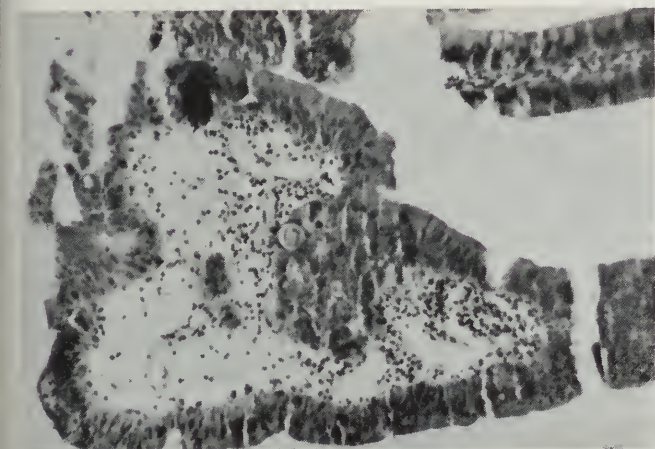


FIGURE 1: Fragment of villous adenoma showing a small focus of frank malignant degeneration.

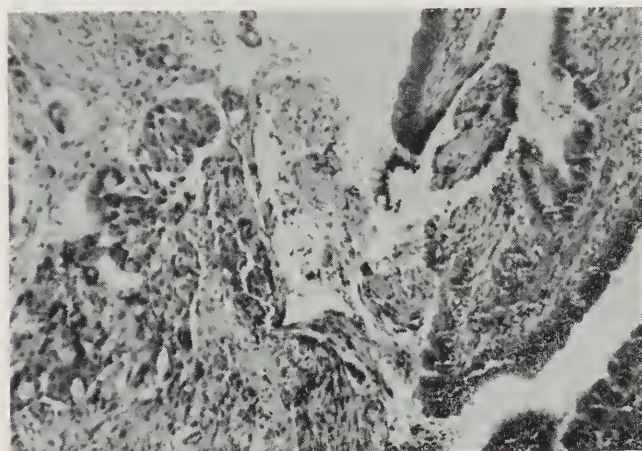


FIGURE 2: Villous adenoma with poorly-differentiated adenocarcinoma infiltrated into the wall.

Following his uneventful postoperative recovery, he was discussed by our Tumor Board and it was recommended that he receive radiation therapy to the pelvis and perineum, then chemotherapy consisting of methyl-CCNU and five Fluorouracil. The patient refused radiation therapy and was started on chemotherapy. He is being followed with frequent CEA determinations, liver scans and close clinical evaluation in Tumor Clinic.

Discussion

Villous adenoma or papillary adenoma is so named because of the presence of frondlike projections. Usually, it is a poorly-demarcated, bulky, broad-based lesion. They are smooth, soft and velvety to the examining finger. Microscopically, there are numerous long villous projections with narrow stroma covered by cylindrical epithelium cells (See Figure 4.)

Villous adenoma is rarely seen under the age of 45. Age distribution reported in the literature²⁻⁵ ranges between 27-93 years of age. It has never been seen in childhood.¹ There is no predominance for either sex. In the United States, Caucasians are affected in approximately 92-95% of the cases and blacks constitute 5-8% of patients seen with this condition.³⁻⁵

The literature was reviewed and in 575 cases²⁻⁵ the most common signs and/or symptoms reported were

- 1 Rectal bleeding 46.2%
- 2 Mucoïd diarrhea 24.9%
- 3 Abdominal pain 12.7%

The severe—depletion syndrome of hypokalemia and dehydration due to severe diarrhea was reported in only 18% of patients in one series,⁴ and to only one in another series of 55 patients.² A few patients have noted changes in the bowel as well as weight-loss and unexplained anemias.

Asymptomatic patients were 20.9% of all cases reviewed. The location of the lesions in this review were in the rectosigmoid in 77.3% of which 35% were detected by the examining finger. Sigmoidoscopy detected 82.7% of the cases and barium enema was indicative of the lesion in 67.3% of the cases.

The size of the lesions ranged from 2-14 cm. and the relationship between the size of the lesion and evidence of malignancy in the particular lesion showed a rather

high correlation. In lesions less than 2 cm., malignancy was approximately 25%. In lesions ranging from 2-5 cm., malignancy was noted in 58.5% and in the largest lesions, over 5 cm. in size, malignancy was present in 80% of the cases;⁵ however, in trying to describe the overall incidence of malignancy of this lesion, one must be aware that the criteria for labeling one of these lesions as malignant in a particular study varied from cellular atypia to those requiring evidence of invasion;⁴ hence, the overall incidence of malignancy in the studies reviewed varied between 35%-58%. It should be noted that associated adenomatous polyps were reported in 25% of patients as was found in our patient.

Treatment varied from local excision via the proctoscope, colotomy with excision of the lesion, the anterior resection and abdominal perineal resection depending upon both location and the extent of invasion.^{3,4} It was noted that there was a high incidence of recurrence in locally excised lesions.³ Overall, the five-year survival rate is reported to be between 75-80%. Because of the rarity of this tumor in the young adult patient and the absence of this tumor in the pediatric population, we are presenting this report.

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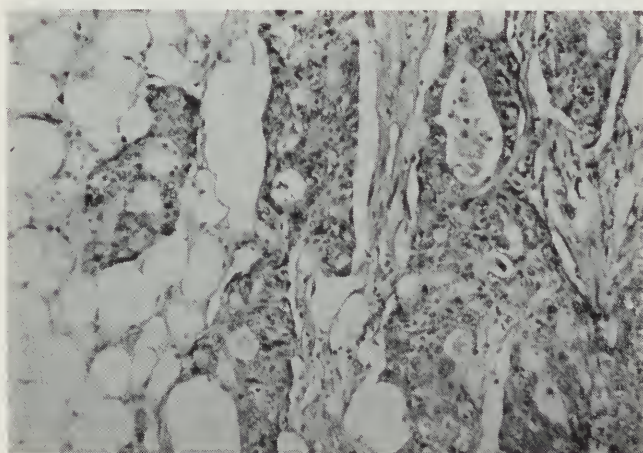


FIGURE 3: Infiltrated adenocarcinoma in pericolic fat.

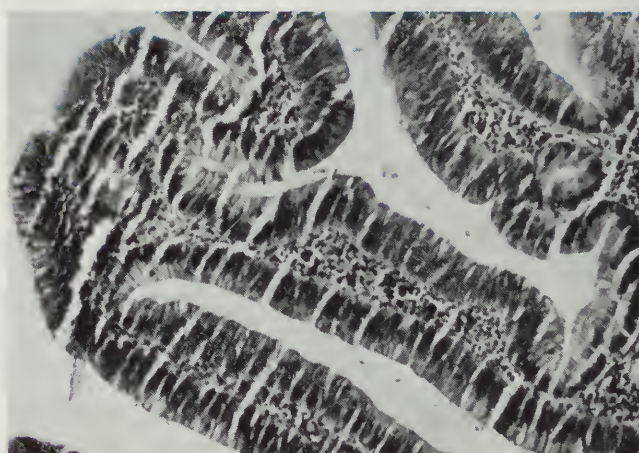
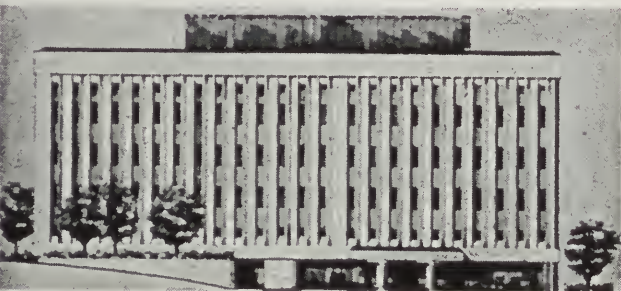


FIGURE 4: Benign villous adenoma.

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A Medical Society's Participation in Health Planning

By ALBERT M. ANTLITZ, MD

Dr. Antlitz is Head of the Division of Cardiology at Mercy Hospital in Baltimore, President of the Baltimore City Medical Society and a Member of the Executive Committee of the Central Maryland Health Systems Agency. For reprint requests, write him at 301 St. Paul Pl., Baltimore, MD 21202.

Health planning has been part of the Maryland scene for the past 10 years, but the interest and involvement of the medical community for much of that time was sporadic, antagonistic and usually ineffectual. The revamping of the health planning structure by the National Health Planning and Resources Development Act of 1974 (PL 93-641) provided an opportunity for fresh input into the planning process which was quickly seized by the Baltimore City Medical Society (BCMS).

Maryland enacted its first health planning law in 1968 to conform with the 1966 Federal Partnership for Health Act (PL 89-749).¹ This law gave birth to the Maryland Comprehensive Health Planning Agency, as the "(a)" agency under the Federal law and authorized the formation of areawide "(b)" agencies as advisory groups. Together, these agencies were responsible for certificate of conformance reviews required for construction or modification of health care facilities and for the development of regional and statewide health plans.

The Regional Planning Council (RPC), composed of the elected officials in Baltimore City and the five surrounding counties, was established by the State in 1963 as the planning agency for the Baltimore Standard Metropolitan Statistical Area. Although not primarily concerned with health planning, it was a natural move for the RPC to become, with some modifications, the Baltimore regional health planning agency under the 1968 law. To comply with the requirement that health planning be done by a coalition of politicians, consumers and providers, the Citizens Health Council (CHC) was formed as the advisory body to the RPC in 1969.²

There was minimal input from the medical community during this time. The BCMS adopted a resolution in October, 1968 recognizing the need for health planning on a regional basis and urging the formation of a Regional Committee for Comprehensive Health Planning. Although the membership of this committee included a representative of each of the six component medical societies in the metropolitan area, the black medical society and the two medical schools in the city, little enthusiasm was generated among the medical societies and, consequently, the manner of selecting physicians to serve on the CHC was left to the planners themselves. Several physicians did serve as members of the CHC and its task forces, but they represented public health, medical schools or other interests; none represented organized medicine or provided feedback to the medical society.

Providers on the CHC were selected through a cumbersome process of delineating broad interest groups and assigning their representatives to panels. In late 1969 and early 1970, there were panels on Ambulatory and Outpatient Care Facilities, Hospitals, Environment, Extended and Nursing Care Institutions, Students in Health Professions, Financing Agents, Health Related and Allied Agencies, Health Officers, Educational Institutions, Voluntary Health Agencies, Independent Private Office Practice and Professional Associations and Licensing Bodies.³ The BCMS was asked to nominate a representative to the Professional Associations and Licensing Bodies Panel which included representatives of medicine, dentistry, nursing, medical technology, dietetics, physical therapy, sanitary engineering, social work, psychology and audiology. Each panel selected a delegate to serve on the CHC. On paper, this assured dialogue with and input from many segments of health care providers. In effect, there was little or no communication. The panels were frequently very large, consisted of diverse interest groups, and met only once or twice each year, all of which combined to negate effective interaction.

In early 1971, the BCMS became concerned with some of the pronouncements emanating from the CHC and a meeting with the Council's Executive Director was held. This resulted in the appointment of a representative to the Project Review Committee, giving the Medical Society direct involvement in the planning process for the first time.

The Project Review Committee was responsible for reviewing proposals for construction of health facilities and making recommendations to the CHC. This link with health planning was tenuous, but did provide the Society with information about the types of activities being undertaken. Although the BCMS representative submitted monthly written reports to the Board of Directors, the Society did not place a high priority on health planning and, for the next three years, was content with simply receiving the reports.

Early in 1974, parts of the CHC draft health plan were distributed and the section dealing with primary care was reviewed by the Society's Health Care Delivery Committee. It was obvious that this plan would affect private physicians as well as hospitals and nursing homes. Concern over the inability of the Society to impact on this plan was voiced at a meeting of officers and committee chairmen in September, 1974 and an ad hoc committee was formed to develop ways in which the BCMS could become more involved in health planning. Shortly thereafter, PL 93-641 was enacted.

Coinciding as it did with the aroused interest in health planning within the Society, this law gave the BCMS an opportunity to regain initiative in the planning process. A campaign to inform physicians about

the new law was begun through the Society's **Newsletter** and reports at meetings. Letters were sent encouraging the Presidents of the five counties surrounding Baltimore City—Anne Arundel, Baltimore, Carroll, Harford, and Howard—to become involved. The Board of Directors passed a motion recommending to the Governor that the Baltimore Metropolitan Area be designated as a health systems area and encouraging the inclusion of organized medicine in the governing structure of the health systems agency.

The health planning agencies also reacted to PL 93-641 quickly and the Regional Planning Council, the Citizens Health Council and Regional Medical Program each formed an ad hoc committee to study implementation of the law. The Baltimore Metropolitan Area was designated a health service area in April, 1975 and the Regional Medical Program and the Citizens Health Council ad hoc committees began meeting together to develop a plan for the formation of a health systems agency. The Regional Planning Council, however, was concerned that the law would limit its authority and was prepared to submit its own letter of intent to develop a health systems agency in the region. After much negotiation, the Regional Planning Council agreed not to submit and joined with Regional Medical Program and Citizens Health Council to develop a new agency.

In June, 1975, the first meeting of the three groups was held and the BCMS was invited to participate as a guest. The interest of the medical societies in the implementation of the law and the formation of the agency was recognized and the BCMS representative was a voting member at the July meeting of the Committee.

Word of the Committee's activities spread throughout the community and professional and community groups not represented appeared demanding membership. When a decision was made to enlarge the membership to 100, i.e. 51 consumers/49 providers, the BCMS sent letters to the county medical societies urging them to appoint representatives to attend the coming meetings and to press for membership.

The importance of joint efforts on the part of the medical societies cannot be underestimated. In the past, governmental agencies had been accustomed to dealing with local medical societies individually. This was the first time that all of the medical societies in the region united and presented an organized position. The county societies were at first leery of the larger City Society and were suspect that the BCMS was attempting to usurp their own prerogatives. Through the efforts of individual leaders within the county and City societies, and because the City insisted on equal representation for each society on the Ad Hoc Committee, the Coalition of Medical Societies was formed and held together. This unity was a major factor in the medical community's ability to successfully impact on the Ad Hoc Committee and later on the health systems agency.

At the time the Ad Hoc Committee of 100 was formed

in October, 1975, a physician from each medical society in the Metropolitan Area had been elected as a member. Task forces to develop the structure and policies of the health systems agency were appointed and medical society representatives served on those concerned with Governance and Membership, Systems Development, Certification and Review, Planning and Education. The physicians serving on different task forces shared their experiences with each other providing broader input into each group and cementing the concept of the Coalition of Medical Societies. Through these efforts, the credibility of the medical societies was established. This reaped dividends later when support was needed for the recommendation that physician members of the Central Maryland Health Systems Agency (CMHSA) Governing Body be selected by the medical societies.

The application submitted to the Department of Health, Education and Welfare called for the appointment of six physicians nominated by the medical societies in the region—one each from Baltimore City and the black medical society (the Maryland Chapter of the National Medical Association) and four from the five counties. This membership formula was accepted when conditional status was granted the CMHSA in June, 1976 and reaffirmed when full designation was received in 1978.

Effective health planning requires the cooperation and support of the medical profession. The medical societies in the Baltimore region have seven representatives on the CMHSA Governing Body and one on the Executive Committee. These physicians and others serving on subarea councils and CMHSA committees are affecting health planning decisions. Physicians and their medical societies can have a marked influence in health planning agencies if they are willing to spend the time and energy necessary to understand and actively participate in the process.

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Doctors in the News

Dr. Weisman Honored

Maxwell N. Weisman, MD has been singled out by his colleagues to receive the highest award given by the Council of State and Territorial Alcoholism Authorities for his contribution to alcoholism program development at the national, state and local levels. The award was presented recently at the CSTAA annual meeting in Oklahoma City.

Dr. Weisman has been the Director of Maryland's Alcoholism Control Administration since its establishment by the State Legislature in 1968. Prior to that time, he had been the Director of Community Psychiatry in the State Department of Mental Hygiene, to which he had been appointed immediately after completing a psychiatric residency in 1962 at the University of Maryland.

Although he had a distinguished career first as a teacher of Latin and then as a Professor of Biology at the University of Puerto Rico, becoming deeply involved in the Island's social and intellectual life through his role as Director of Veteran's Education in the Puerto Rico Department of Instruction, he decided to embark on the study of medicine when he was past 40 years of age. Too old to be admitted to medical schools in the United States, he went to the Netherlands and was graduated from the University of Amsterdam Medical School in 1958.

Fluent in six languages, Dr. Weisman is Past President of the American Medical Society on Alcoholism and serves on the Faculty of many university-based schools of alcohol studies including the Rutgers University and Utah University Summer Schools in addition to Johns Hopkins University and the University of Maryland. He is known and respected as an international authority and lecturer on the medical aspects of alcohol abuse and alcoholism. While in the Netherlands, he served as an editor with

Excerpta Medica in the fields of ophthalmology, obstetrics and gynecology and general psychiatry.

Commenting on the occasion at the formal presentation, the President of CSTAA indicated that Dr. Weisman had been selected for this prestigious award after all 56 State and Territorial Alcoholism Directors had been surveyed, and in recognition of Maryland's outstanding alcoholism program.

Dr. Handelsman Receives Golden Apple Award

Jacob C. Handelsman, MD, Attending Surgeon at Sinai Hospital in Baltimore, is the latest recipient of Sinai's Golden Apple Award.

The Golden Apple is given several times each year by the Hospital Staff Association for excellence in teaching and dedication to the medical profession.

Dr. Handelsman, who was interim Co-Chairman of Surgery during most of 1977, is the ninth recipient of the award.

Other members of the Golden Apple Society are Drs. Samuel J. Abrams, Jerome P. Reichmeister, Herbert L. Yousem, Leon G. Sheer, Juan M. Juanteguy, Ernest Scher, Belur S. Bhagavan and Melvin L. Keller.

The author of innumerable professional publications, Dr. Handelsman is a member of many professional associations, including the American College of Surgeons, the Society of University Surgeons and the Baltimore Academy of Surgery, AMA, the Baltimore City Medical Society, Med-Chi and also serves on the Board of Directors of Blue Shield of Maryland. □

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ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, erythema, pruritus. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'illon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).



Motrin⁴⁰⁰ TABLETS

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Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Postoperative Pulmonary Insufficiency: Better Prognosis With Appropriate Therapy

By ABDALLAH ALAMEDDINE, MD

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Introduction

A retrospective analysis was made of the data on 78 patients who had lung problems as part of their very serious illnesses and treated in the intensive care unit with mechanical respiratory assistance following major surgery in a 17-month period in 1974-75. Most

of the patients reported had more than one complication in addition to their pulmonary problems (Table 4). The analysis yielded 18 patients (Group 1) who required ventilatory support for more than three days. Sixty patients (Group 2) were extubated before 72 hours. Hospital mortality rate was 56% in Group 1, where the major cause of death was non pulmonary in 90% of cases (Table 3). In Group 2, 15% of the patients died, all from non-pulmonary causes.

This paper calls attention to the problem of pulmonary complications, in particular pulmonary insufficiency, in the postoperative period, and sheds indirect light on the prognosis. Although none of the therapeutic maneuvers is original, this study emphasizes that with a specific plan of therapy—and if the patient's primary disease is recoverable—then the pulmonary complication is of little prognostic importance.

Several authors have documented

a high incidence of pulmonary complications following surgery, in particular, pulmonary insufficiency, which continues to present problems in management to both the physician and surgeon. Meticulous preoperative preparation, efficient surgical technique and intensive postoperative care are of utmost importance¹ to decrease mortality and morbidity.

Materials and Methods

The present study was conducted on 78 patients suffering from postoperative respiratory failure who were managed in the Intensive Care Unit, at Union Memorial Hospital in Baltimore, by mechanical ventilatory support. These patients came to the unit following their surgery for one reason or another, not always because of actual respiratory distress, but in some instances in the hope of avoiding it.

Some of them came from the operating room with an endotracheal tube and being supported by a ventilator, i.e., judged necessary in

Table 1: Age Distribution of 78 General Surgery Patients who had Postoperative Respiratory Support

Group 1 Number of Patients	Age	Group 2 Number of Patients
	0-19	
1	20-29	2
2	30-39	3
3	40-49	4
	50-59	12
2	60-69	14
8	70-79	15
2	80	10
18	Total	60

Table 2: Type and Place of Incisions Used

Group 1	Incision	Group 2
10	Abdominal-laparotomy	44
3	Craniotomy	6
3	Thoracic	3
1	Cervical	
	laminectomy	2
	Neck	2
	Thoraco-abdominal	2
1	Extremity	1
18	Total	60

Table 3: Clinical Features and Survivals

	Age		Issue		Average Duration on Ventilator
Group 1	F	31	Alive	51	24 Hours
	M	29	Died	9*	
	60 y	65%			
Group 2	F	3	Alive	8	6 Days
	M	15	Died	10**	
	60 y	67%			

* All from non-pulmonary causes

** Only one died primarily of pulmonary insufficiency (ARDS)

Table 4: Group 1 Patients* Age, Sex, Clinical Resume and Cause of Death

Patients	Age and Sex	History	Incision	Issue	Major Cause of Death	Duration of Therapy
M.M.	79 F	Fractured femur	Extremity	Died	Renal failure	4 days
S.V.	81 M	Colon carcinoma	Abdominal	D	Myocardial infarction	2 weeks
E.B.	33 M	Mediastinal mass	Thoracotomy	D	Adult respiratory distress syndrome	2 weeks
G.M.	76 M	Tongue carcinoma	Neck	Alive	.....	4 days
Y.B.	70 M	Empyema	Thoracotomy	A	.....	6 days
E.R.	71 M	Glioblastoma	Craniotomy	A	.....	4 days
J.H.	63 M	I.V. cava clip	Abdominal	D	Cerebral vascular accident	5 days
L.W.	47 M	Subdural hematoma	Craniotomy	D	Cerebral hemorrhage	6 days
M.G.	25 M	Multiple G.S. wounds	Abdominal	D	Gram sepsis	1 week
B.N.	75 M	Lung carcinoma	Thoracotomy	A	.....	2 weeks
A.C.	64 M	Profundaplasty	Extremity	D	Renal failure	4 days
C.W.	79 M	Peptic ulcer	Abdominal	A	.....	5 days
C.K.	83 M	Colon carcinoma	Abdominal	D	Congestive heart failure	4 days
B.A.	41 F	Morbid obesity	Abdominal	A	.....	6 days
G.P.	34 M	Portal hypertension	Abdominal	D	Hepatic coma	10 days
M.K.	77 F	Intestinal adhesions	Abdominal	A	.....	4 days
C.T.	44 M	Morbid obesity	Abdominal	A	.....	4 days
H.M.	74 M	Colon carcinoma	Abdominal	D	Myocardial infarction	6 weeks

* All Caucasians

the opinion of the operating surgeon or the anesthesiologist conducting the case; others had respiratory distress as one phase of their complex problems. However, none of these patients did have signs of respiratory failure preoperatively.

There were 44 males and 34 females. All of them underwent major surgical procedures done under general anesthesia. Open heart cases, flail chest and burn patients were excluded. For practical purposes, the diagnosis of acute respiratory failure (ARF) was made in any postoperative patient with an arterial oxygen pressure (PaO_2) of less than 60mm. of mercury; or a PaCO_2 of more than 50mm. of mercury. Standard principles of homeostatic support applied to all patients and will be briefly touched upon: preoperative assessment and therapy in high-risk patients (obese, aged and patients with COPD), which consists of functional lung study, continuous administration of moist air, deep breathing exercises, incentive spirometer continued by postural drainage with nasal oxygen, endotracheal intubation and ventilatory of positive end-expiratory pressure (PEEP) supports for pulmonary failure, hypoxia and pneumonia.

Table 5: Overall Complications

Pulmonary	
Pneumonia	15
Atelectasis and/or infiltrate	6
Pleurisy	4
Shock lung (ARDS)*	1
Empyema	1
Lung edema	1
Pneumothorax	1
Cardiovascular	
Myocardial infarction	3
Congestive heart failure	2
Foot gangrene	1
Central Nervous System	
Cerebral vascular accident	3
Meningitis	1
Gastrointestinal	
Stress ulcer	2
Peritonitis	2
Renal	
Acute renal failure	4
Infections	
Sepsis	2
Wound infection	1
Liver	
Hepatic coma	1
Miscellaneous	
Tracheal stenosis	1
Evisceration**	2

*Adult respiratory distress syndrome

**Two cases of ileo-jejunal bypasses for morbid obesity

Bronchoscopy is repeated, as often as necessary, during treatment for tracheal toilet and evaluation of therapy. Antibiotics were given prophylactically in some cases. Sixty-three patients were on Emerson volume-cycled respirator, 12 were on the Engstrom and three on the Bennett PR-1 pressure-cycled machine.

The age distribution is shown in Table 1. The patients were divided into two groups on the basis of the length of continuous respiratory assistance: Group 1 patients required mechanical ventilatory support for more than three days; PEEP was used in half of this group with a range between 2.5 and 10 cm. of water. Fifteen had abdominal and/or thoracic surgery, two craniotomies and one patient with open reduction fracture femur. There were three females and 14 males; 67% were more than 60 years of age. Ages ranged between 25 and 83 years. Group 2 patients were extubated before 72 hours. There were 31 females and 29 males. Patients over 60 years of age composed 65% with a range between 25 and 93 years. Six craniotomies were included in the group. The average period of treatment on respirator was 24 hours. The fraction oxygen in inspired gas (FIO_2) and minute volume (MV) were adjusted, after the initial setting, according to the blood gases. Wright respirometer was used for monitoring the tidal volume (TV) and minute ventilation. The Inhalation Therapy Department of the Union Memorial Hospital checked ventilators daily. (See Table 1).

Results

1. Clinical features: Of the entire series, 59 patients survived and 19 patients (25%) died, but only one (1.2%) died primarily of pulmonary insufficiency. The antecedent surgical incisions that precipitated ARF and pleuropulmonary complications were abdominal in 54 patients (70%), craniotomies in nine, thoracic in six, cervical spine in three; neck, thoracoabdominal and extremity operations in two patients each (Table 2). In Group 1 patients, the average PaO_2 , PaCO_2 , postoperatively and before the ventilatory support, were 46 and 28 mm.

Hg. respectively, with respiratory rate and radial pulse of 28 and 120 per minute.

2. Factors in connection with postoperative pulmonary complications: No control study was undertaken in conjunction with those two groups; overall, men were more prone than women; the incidence of complications increased with age, the highest being in patients aged over 60 years. Taking the series as a whole, the type of incision (abdominal), blood loss (500 cc.), obesity and duration of the operation (two hours) did, indeed, affect the incidence of complications.

3. Complication and survivals: The hospital death rate in Group 2 was 15%, all from "non"-pulmonary causes (Tables 3 and 4).

In Group 1, the major cause of death was non-pulmonary in 90% of the cases. Nine patients had tracheostomy performed for better respiratory care or for prevention of laryngotracheal complications. Mono or polymicrobial with a mixed flora of *Klebsiella*, *Pseudomonas* and *enterobacter*, were the bacteria most frequently encountered on sputum and/or tracheal stoma cultures.

Discussion

Following surgery, pulmonary complications continue to be a major cause of morbidity and death.² Complications may be expected as low as 3% of all operations,³ though the incidence of "miliary" atelectasis is much higher than this figure. Thirteen percent of postoperative deaths are due to pulmonary complications. In one series, the problem of ARF arose in 2.4% of all major operations.⁴ The survival rate in patients over 50 years of age was 54%.⁵

Chronic bronchitis, heavy smoking, old age, severe obesity, premedications, general anesthesia, proximity of the operative field to the diaphragm, prolonged operation, postoperative pain and sedatives, dressings and binders, immobility and over-hydration all interfere with the breathing pattern, predispose to the "restriction" of the ventilation and increase the incidence of atelectasis.⁶⁻¹⁰ Management of these patients starts before the sur-

gical procedure. A special "program" must be followed. The latter will be discussed briefly; it consists of the following:

1. Preoperative assessment of all high-risk patients: The history, physical examination, chest X-rays, ECG, blood gases and pulmonary function tests provide the best picture of a patient's pulmonary status.^{1,11-12} There are more sophisticated studies assessing closing volumes of the lung for early detection of small airway disease.¹³⁻¹⁴ The use of IPPB and prophylactic antibiotics in managing pulmonary problems are controversial.¹⁵⁻¹⁷ Short-term abstinence (three days) from smoking and incentive spirometer play their major roles in the preoperative preparation.¹⁸⁻¹⁹

2. At operation: Periodic over-inflation of the lung and avoid denitrogenation to prevent alveolar collapse.²⁰

3. Postoperatively: The importance of coughing, deep breathing chest physiotherapy and postural drainage, early ambulation and sitting position,²¹⁻²² avoidance of narcotics, tracheal aspiration and bronchoscopy when indicated cannot be over emphasized.²³ Because of the paucity of signs and symptoms, blood gases analyses and chest X-rays are required as means of prediction of pulmonary complications and follow-up. Ventilators are indicated whenever the patient is unable to maintain adequate ventilation on his/her own. We do believe, like many others,²⁴ that for prolonged use (more than 24 hours), a volume-limited respirator is superior to a pressure-limited device in several respects (better oxygenation and effective compliance). Oxygen concentration greater than 50% should be used under rare circumstances²⁵ because of its presumed deleterious effects on the lung.

If the PaO_2 is less than 50-60 mm. Hg. on 50%-inspired oxygen, then it is probably preferable to introduce PEEP,²⁶ needless to mention that secretions must be removed before starting it.²⁷ D.G. Ashbaugh, et al, have mentioned the continuous positive-pressure breathing (CPPB) in ARDS.²⁸ High-volume, low-pressure cuffs should be

used in an effort to decrease the incidence of tracheal injury and aspiration pneumonia.²⁹ There is currently good data in the medical-surgical literature on the criteria for weaning patients from respirators.

These include knowledge of pulmonary gas exchange with arterial blood gases obtained on air and oxygen breathing with calculation of alveolar-arterial differences for oxygen. Also included are measurements of mechanics including tidal volume, respiratory rate, inspiratory force and dynamic compliance,^{5,9} etc. A new approach to weaning, "intermittent mandatory ventilation" (IMV), has recently been described.³⁰

Summary

Postoperative pulmonary insufficiency taxes the morbidity and mortality of many operative procedures. It is of major clinical importance. In a series of 78 consecutive patients presenting ARF at one time of their postoperative hospital course, the overall mortality was 25%, but 1.2% died primarily of pulmonary insufficiency. Many conclusions can be drawn from our findings: the recent advances in anesthesia, a better understanding of the use of fluids and electrolytes—both during and after surgery—and careful mechanical ventilation could be cited as reasons for the lower incidence in our study. Also, this small series serves to emphasize that early recognition of pulmonary complications, the pre- and postoperative aggressive management and judicious and "prophylactic" utilization of respirators will aid in reduction of mortality in these critically-ill patients.

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Low-Dose Heparin Preoperatively for Prophylaxis Against Postoperative Thromboembolism

By OTTO C. BRANTIGAN, MD

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Method

The study covers a three-year period from Nov. 22, 1972-Nov. 21, 1975. All patients were private patients of one surgeon who managed the patient throughout the hospital course and during the follow-up period. All patients 40 years of age or older who had an elective major surgical operation under general anesthesia were given low-dose heparin 18-24 hours before surgery and low-dose heparin was continued for 48 hours after surgery.

All control patients were 40 years of age or older and all had a major operation under general anesthesia. The controls were two groups.

One group of controls consisted of patients operated upon by other surgeons at St. Joseph Hospital who did not use prophylactic heparin. The operating room nurses selected and matched the prophylactic low-dose heparin patients with patients by other surgeons not treated with heparin, age for age, sex for sex, duration of operation and, when possible, type of operation, and, finally, patients operated upon within one week in order to rule out seasonal variations.

The second control group of patients was consecutive patients 40 years of age or older who, during a three-year period preceding the study, had major surgery by

the surgeon carrying out the study. In the study patients and in the control patients, orthopedic and neurosurgical patients were excluded; patients requiring emergency operation were excluded, also, since there was insufficient time to carry out preoperative heparin therapy.

Sodium heparin, 2,000 units, was given subcutaneously at 4 and 10 PM on the day prior to operation and on the day of operation at 6 AM if the operation was scheduled before noon, and at 8 AM if scheduled after noon. Postoperatively, heparin was given every eight hours for six doses beginning at 10 PM the day of operation. The heparin-treated patients in the study and the control untreated patients of the surgeon doing the study were followed after leaving the hospital for at least three months. The untreated control patients selected by the operating room nurse were observed only to the date of discharge from the hospital, and this could be a period as short as four or five days.

The total number of patient admissions, the total number of operations, with the total number of complications of phlebitis, phlebotrombosis, thrombophlebitis, pulmonary embolism and pulmonary infarction at St. Joseph Hospital was obtained for the corresponding six-year period covered by the study. These admissions include

●
Postoperative thrombophlebitis—with its sequelae of the possible pulmonary embolism, with its ever-present threat of death and the threat of a lasting, chronically-swollen leg—continues to be an important, though clinically an infrequent, complication of major surgery.

The frequency of phlebitis, phlebotrombosis, thrombophlebitis, pulmonary embolism and pulmonary infarction is difficult to state in a simple numerical manner. There are many ways of reporting these conditions, making comparisons worthless.

MacLean, in 1916, isolated a substance named Heparin by Howell and Holt in 1918. Mason, in 1924, reported use of heparin in the prevention of experimental thrombosis and embolism.¹

Sharnoff² in 1966 began the preoperative prophylactic use of heparin to avoid postoperative thrombophlebitis. After a report by Boyd,³ followed by a long and far-reaching discussion of the effects of low-dose heparin given at the American Association for Thoracic Surgery at the annual meeting in 1972, a program of prophylactic, preoperative, low-dose heparin was started at the St. Joseph Hospital.

all ages, and all diseases, regardless of the service in the hospital and those with and without operation (Table 1).

Results

The compiled results are shown in Table 2. There were, in the three-year period of the study, 333 patients treated with low-dose heparin who were over 40 years of age and who had a major operation under general anesthesia. None were orthopedic or neurosurgical patients. Of the 333 low-dose, heparin-treated patients, three had a thromboembolic complication. One was a 53-year-old woman who had a repair of a hiatal

hernia, repair of gastroesophageal junction, selective gastric vagotomy, antral resection of the stomach and an appendectomy. She developed atelectasis of the lung, followed by pneumonitis and fever. She developed thrombophlebitis of the right leg 17 days after surgery—in fact, 15 days after the last treatment with low-dose heparin; she recovered.

There was a 44-year-old male who had a simple cholecystectomy. He developed phlegmasia cerulea dolens on the seventh day after surgery. He recovered. The third patient was a 57-year-old, very obese man. He was admitted as an emergency with left lower qua-

drant pain. There was a differential diagnosis of acute sigmoid diverticulitis and perforating large abdominal aortic aneurysm. He was kept in bed for observation and then prepared for abdominal aneurysmal surgery, which was accomplished six days after admission with ease and with the use of two units of whole blood. (He was operated upon the last day of the study.) On the fifth postoperative day, he died (five days after the study was completed.) An autopsy revealed a massive pulmonary embolism and diverticulitis of the sigmoid. There were no complications as a result of the use of low-dose heparin.

Table 1: Six-Year Total Admissions and Surgical Operations—All Ages—
St. Joseph Hospital, Towson, MD

Year	Total No. Admissions	Total No. Operations	Total No. Pulmonary Embolism Infarctions	Total No. Phlebitis Thrombophlebitis	Total No. Embolism Phlebitis Thrombophlebitis
1976	12,844	7,681	87	82	169
1971	14,296	8,404	94	87	181
1972	14,802	8,905	94	119	213
1973	15,522	9,350	90	109	199
1974	16,049	11,365	78	135	213
1975	16,384	11,559	70	107	177
Six-Year Totals	89,897	57,264 (64% of Admissions)	513	639	1,152 (1.3 per 100)

Table 2: Prophylactic Low-Dose Heparin

Previous Three-Year Surgical Control			Prophylactic Low-Dose Heparin		Nurse-Selected Surgical Control	
Year	No. Patients Major Surgery	Phlebitis Thrombophlebitis Pul. Embolism	No. Patients Major Surgery	Phlebitis Thrombophlebitis Pul. Embolism	No. Patients Major Surgery	Phlebitis Thrombophlebitis Pul. Embolism
1970	105	2				
1971	99	4				
1972	119	3				
1973			111	1	111	1
1974			123	1	123	8
1975			99	1	99	1
Totals	323	9 (2.8 per 100)	333	3 (.9 per 100)	333	10 (3.0 per 100)

All patients 40 years of age or older had major surgical operation under general anesthesia. None were orthopedic or neurosurgical.

There were no patients with a bleeding tendency. (It actually seemed to eliminate the rare patient who exhibits a bleeding tendency at the time of operation.)

In the control group operated upon over a three-year period previous to the study, there were 323 patients. In this group, there were nine patients with thrombophlebitis and no patient with pulmonary embolism. In the nurse-selected control group of patients, there were 333 patients. In this group, there were 10 patients with thrombophlebitis, and no patient had pulmonary embolism.

Discussion

It has been shown that minute amounts of heparin will increase by 50 or more times the effectiveness of the activated factor X inhibitor in blood.⁴⁻⁶ It is this fact that makes low-dose heparin effective.

The 2,000-unit sodium heparin dose used three times prior to surgery and six times after surgery was selected after listening to the comprehensive discussion of the use of low-dose heparin at the 1972 annual meeting of the American Association for Thoracic Surgery.³ Reports in the literature since the beginning of the present study indicate the use of a larger dose of heparin.⁷ In this series with prophylactic heparin, there was no patient with a bleeding problem during or after surgery. There was no patient with a hematoma. It seems as though the low-dose heparin eliminated the rarely-encountered patient who has a bleeding tendency at the time of operation. This conclusion is reasonable when the report of Boyd and the discussion of his report is considered.

From what is generally believed about thrombophlebitis, it seems that the first patient really should not be counted in the series, since one cannot expect prophylaxis against thrombophlebitis 15 days after low-dose heparin was discontinued. The last patient, unfortunately, was kept in bed six days prior to surgery, and it can be believed difficulty with blood clotting began before prophylactic low-

dose heparin was administered. Low-dose heparin cannot be expected to be effective once the process of blood-clot formation has already begun. If these two patients are eliminated from the study, then the rate of thrombophlebitis after the use of low-dose heparin is .3 per 100, instead of .9 per 100.

The study strengthens the common belief that obesity and bed rest prior to surgery are potent factors in development of thrombophlebitis. The development of complications after surgery, especially febrile complications, should be considered an important factor in the development of thrombophlebitis. It may be worthwhile to prescribe low-dose heparin if the patient is given bed

rest preoperatively, or if a patient has fever after operation.

The incidence of the complication of thrombophlebitis and pulmonary embolism is difficult to assess by study of the literature. There are many different methods of reporting.⁸⁻⁹ The incidence of clinical thromboembolism is, therefore, compared with the incidence found in all patients admitted to St. Joseph Hospital (Tables 1 and 3) during the time of the control period and the study period.

The incidence given by radioisotope¹⁰ study gives the astounding figures of about 25 per 100 (Table 3). This seems incredible and incorrect, unless the incidence of venous thrombosis found at necropsy is considered which ranges from 27-60 per 100 (Table

Table 4: Incidence of Venous Thrombosis Determined by Necropsy

Name	Year	Cases	Thrombosis of Calf Veins	
Rossle	1937	324	88	27.1%
Neuman	1938	165	100	60.0%
Hunter and Others	1941	351	185	52.7%
Hunter and Others	1945	400	206	51.5%
Putzer	1939	370	100	27 %
Greenstein	1945	100	51	51 %
Raeburn	1951	130	35	26.9%
Totals		1840	765	41.5%

Modified from N.M. Gibbs¹¹

Table 3: Incidence of Phlebitis, Thrombophlebitis and/or Pulmonary Embolism

Source of Material	Number of Patients	Number per 100 Patients
Clinical method of determination Six-Year Total Admissions, St. Joseph Hospital	89,897	1.3
Clinical method of determination Previous Three-Year Surgical Controls	323	2.8
Clinical method of determination Nurse Selected Surgical Controls	333	3.
Clinical method of determination Prophylactic Low-Dose Heparin	333	.9 (.3)
Nuclear isotope scan determination Kakkar 1975 ¹⁰	667	24.6
Necrosy method of determination N.M. Gibbs 1957 ¹¹	1840	41.5

4).¹¹ In the necropsy study, it is easy to believe the findings are a late stage because death occurred; however, the isotope and necropsy incidence cannot be disregarded. The results of necropsy and isotope study reflect the ability of laboratory studies to detect blood clotting when it cannot be found clinically by physical findings in the living patient who has no symptoms. It seems reasonable that more clinical study is needed to further elucidate the disease. Perhaps in this way those patients who are not spared from the postoperative complication of thrombophlebitis can be saved from pulmonary embolism and/or death by early treatment with full heparin dosage.

Summary

The results of the use of prophylactic low-dose heparin in 333 patients 40 years of age or older who had a major operation under general anesthesia have been given. The incidence of phlebitis, phlebotrombosis, thrombophlebitis or pulmonary embolism was .3 per 100 patients. In 653 control pa-

tients, the incidence of phlebitis, phlebotrombosis, thrombophlebitis and pulmonary embolism was 2.9 per 100 patients.

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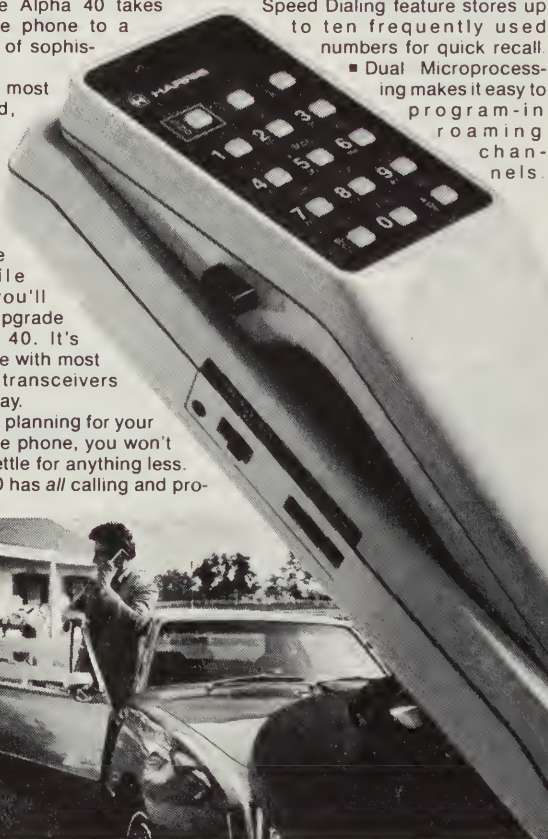
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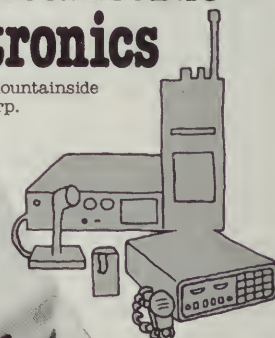
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The Clinical Significance of the Hepatitis B Surface Antigen

By RICHARD E. SAMPLINER, MD

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The Australia Antigen was discovered by Blumberg in 1964¹ and related to clinical hepatitis in 1967. The recognition of this antigen has led to many new and exciting advances in our understanding of liver disease and its transmission. Because the Hepatitis B virus has never been grown in tissue culture, the antigen has served as a marker of the virus and the key to recent developments. Over the years, this antigen had been called the Australia Antigen, the Hepatitis Associated Antigen and, currently, the Hepatitis B Surface Antigen (HBsAg). However named, the antigen remains the only marker of the hepatitis B virus that is routinely available in the clinical setting.

The HBsAg is only one of the immunologically-recognizable products of the Hepatitis B virus. The others are the core antigen and the "e" antigen. Both the surface and core antigens can be found in the liver cell. The host hepatocyte produces HBsAg under the direction of the genome. Great excess of HBsAg is manufactured and circulates in the serum, where it can be detected by current radioimmunoassay techniques. The Hepatitis B virus also produces the enzyme DNA polymerase.

A major clinical significance of HBsAg is as a marker of liver disease. The spectrum of liver disease includes acute Hepatitis B, chronic active hepatitis and primary hepatocellular carcinoma. Acute Hepatitis B or serum hepatitis can be diagnosed when HBsAg is present in the serum. This long incubation hepatitis is now recognized to be transmitted nonparenterally as well as parenterally and occurs primarily in adults. Hepatitis B accounts for at least half of sporadic adult acute viral hepatitis. HBsAg is almost always detectable at some point in the course of Hepatitis B. It can be detected during the incubation phase for as long as one month prior to the onset of symptoms and usually disappears from the serum with resolution of the clinical illness. Hepatitis B contrasts with Hepatitis A, "infectious hepatitis," which has a shorter incubation period, is transmitted by the fecal-oral route and occurs commonly in children.

HBsAg is present in as many as one-third of patients with chronic active hepatitis. The liver disease is thought to be an immunologic reaction to the Hepatitis B viral infection. The availability of testing for HBsAg has led to the documentation of the progress of acute viral hepatitis to chronic liver disease and cirrhosis in prospective studies of patients with persistent anti-hepatitis B surface antibody. A one-to-five-year follow-up of more than

400 patients hospitalized with acute icteric Hepatitis B revealed that 10% had HBsAg in their serum persistently and developed chronic hepatitis, while three percent developed specifically chronic active hepatitis.²

HBsAg is dramatically associated with primary hepatocellular carcinoma in Africa and Southeast Asia. Although a less common finding in the United States, evidence of Hepatitis B infection can be found in 40% of patients with primary hepatocellular carcinoma.³ In addition, a small number of chronic carriers of HBsAg with liver disease have been documented to develop primary liver cancer. The key unanswered question is whether chronic carriers without underlying liver disease will develop an increased frequency of this cancer over their lifetimes.

All patients with HBsAg do not have liver disease. Apparently well individuals found by chance to have HBsAg are usually chronic carriers. By definition, a chronic carrier is an individual who has circulating HBsAg for at least six months. Although there is evidence of a genetic predisposition for the carrier state, it is not clear why some individuals remain chronic carriers and are unable to clear the virus. The frequency estimates of chronic carriers has a marked geographic variation from less than one percent in the US to 6-10% in the sub-Saharan region of Africa and Southeast Asia.⁴ Although most chronic carriers are free of liver disease, 10% of apparently healthy carriers have chronic active hepatitis and/or cirrhosis by liver biopsy. This frequency of significant liver disease in chronic carriers of HBsAg has been confirmed in the Baltimore area.⁵ Why some chronic carriers respond to the HBsAg with liver disease and others do not is unclear.

The detection of HBsAg in the serum of a patient implies infection of the liver by the Hepatitis B virus. The clinician must then determine if the viral infection has resulted in a disease state in the host. Liver enzymes need to be performed and, if elevated, repeated. If the liver enzymes are markedly elevated and the clinical picture is unclear, liver biopsy is indicated. The patient with normal enzymes should have the chronic carrier state documented by repeat HBsAg testing in six months. Persistently abnormal enzymes and persistent HBsAg for six months indicate the need for liver biopsy to exclude chronic active hepatitis.

Another important clinical implication of HBsAg is infectivity. Patients with HBsAg are a potential source of infection to the medical and general community. HBsAg has been detected in blood, bile, stool, urine, tears saliva, semen, milk and vaginal, peritoneal and pleural fluids. All of these possible modes of infection have not been proven and do not hold the same risk of transmission. Blood is clearly an important route—

at least 50% of recipients of HBsAg positive transfused blood will develop clinical hepatitis. About six percent of individuals stuck by a needle known to be contaminated by HBsAg positive blood develop hepatitis.⁶ The danger of blood exposure holds for any percutaneous manipulation—sharing of needles for drug administration, tattooing, acupuncture, barber and manicurist instruments, shared razor blades, the neurologic needle. The risk of transmission is related to the size of the inoculum.

Although the saliva of patients with acute hepatitis and of chronic carriers of HBsAg has been demonstrated to contain HBsAg,⁷ transmission by saliva has not been documented. In animal studies, transmission of Hepatitis B virus has been shown only with subcutaneous inoculation, not with lesser exposures. The role of sexual intercourse in transmission of Hepatitis B is highlighted by the high frequency of symptomatic hepatitis in the spouses of patients with acute Hepatitis B. The frequency of hepatitis B serologic markers in a homosexual population relates to large numbers of sexual partners and the predominance of anal intercourse;⁸ however, the role of vaginal intercourse in the transmission of hepatitis has not been ascertained.

Because not all individuals with HBsAg seem to transmit Hepatitis B, the identification of markers of infectivity has been an active area of investigation. The "e" antigen, DNA polymerase and Dane particle—the complete virion—have all been related to infectivity. The "e" antigen is only found in the presence of HBsAg and identifies an individual more likely to transmit Hepatitis B. This marker is not the final answer, however, for everyone with "e" antigen does not transmit hepatitis and individuals without "e" antigen can transmit the disease.⁹

Given the existence of chronic carriers and our inability to precisely define the route of transmission or the risk of transmission by a specific person, we are left to find measures to prevent the spread of Hepatitis B. Currently, there is no way to eliminate the circulating HBsAg from an individual's serum. A small percent of chronic carriers spontaneously clear HBsAg, but we cannot rely on this fortunate event. To a large extent, the prevention of the spread of Hepatitis B rests with increased personal and environmental hygiene by both infected and exposed individuals. Care in the handling of blood and all biologic materials and appropriate sterilization of instruments are essential. If a definite parenteral exposure to Hepatitis B occurs, then prophylaxis with hepatitis B immune globulin—a preparation with a high titer of antibody to HBsAg—is necessary.¹⁰ Individuals such as household contacts with nonparenteral, yet intimate exposure to patients with acute hepatitis B should receive standard immune serum globulin. A Hepatitis B vaccine now ready for trial in humans offers hope for the future prevention of Hepatitis B transmission.

Over the past decade, the clinical significance of HBsAg has been elucidated. As a marker of the Hepatitis B virus, HBsAg signifies the possibility of both liver disease and transmission of Hepatitis B.

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Doctors in the News

Torrey Brown Named Director of Outpatient Services at Hopkins; Reelected to House of Delegates

Dr. Torrey C. Brown has been named Director of Outpatient Services and the Office of Health Care Programs and Assistant Dean for Clinical Programs at The Johns Hopkins Medical Institutions in Baltimore. In his new capacity, Dr. Brown will be responsible for the management of all Johns Hopkins Hospital outpatient services and will coordinate the School of Medicine's clinical service programs. The announcement was made by Dr. Robert M. Heyssel, Executive Vice President and Director of the Johns Hopkins Hospital.

Dr. Brown, who is also Associate Professor of Medicine and Assistant Professor of Health Services Administration, played a central role in developing and managing several Hopkins community health programs. Among them are the Johns Hopkins Drug Abuse Center, the Johns Hopkins Alcoholism Programs, the University Health Services and the Broadway-Orleans Health Clinic.

"I look forward to challenging and exciting times ahead, as the role of ambulatory services in serving the public's medical needs continues to grow," Dr. Brown says. "With several thousands of our East Baltimore neighbors looking to Hopkins as their family doctor, we have a particular responsibility to explore innovations in outpa-

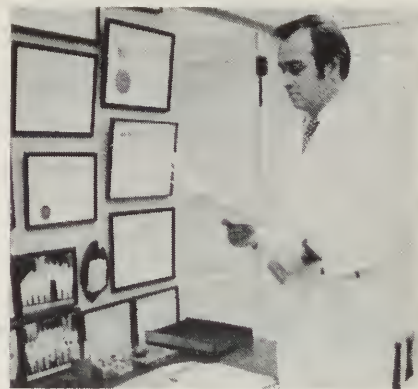
tient care, while continuing to improve existing programs.

"An immediate concern is the planning of an Adult Comprehensive Care Unit similar to that already successfully providing care on a regular basis to children. At present, 30% of the patients seen in our emergency room actually belong in an outpatient clinic. We believe very strongly they should not be seen on an episodic, one-shot basis, even in a clinic. Instead, we want to provide a place where whole families or households can receive continuous, more effective care."

Dr. Brown has been associated with Hopkins for most of his medical career since graduating from the School of Medicine in 1961. Appointed in 1966 as Director of the Hospital's emergency services, Dr. Brown helped to start a system which relieved the emergency room of some non-emergency cases and evolved into the Hospital's Primary Care Center, which has been under his direction since 1976.

As Associate Director and then Director of the Johns Hopkins Drug Abuse Center from 1970-73, Dr. Brown was responsible for greatly expanding the services available to the community at the Center. In addition, he was instrumental in gaining community acceptance and, therefore, greatly increased the patient population. Since 1969, he has served as Director of the Johns Hopkins Hospital Alcoholism Programs.

Under Dr. Brown's leadership, the University Health Services,



DR. BROWN

(Photo by Paul F. Schlining, Jr.)

which provide medical care benefits and programs to Hopkins students, faculty and staff, made several advances. Nurse practitioners and nurse midwives began to offer care, and an unwieldy array of benefit and insurance programs was greatly streamlined. He was instrumental in planning and operating the Broadway-Orleans Health Clinic, a major outreach effort into the East Baltimore community.

Since 1974, Dr. Brown has been a member of the Maryland State Legislature, serving first as Delegate from Baltimore's Second District and currently from the 39th District (to which seat he has just been reelected.) He has served on numerous statewide committees dealing with health problems, and was interviewed in the *Journal* in January, 1977.

Dr. Brown, 41, was born in Chicago, and received his undergraduate degree in 1957 from Wheaton College in Illinois. He served his internship and residency at Hopkins, and was given a faculty appointment at the School of Medicine in 1966. He and his wife, Donnajeane, have two sons, Therron and Rafe. □



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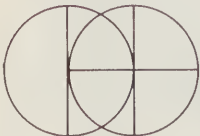
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*** Warning**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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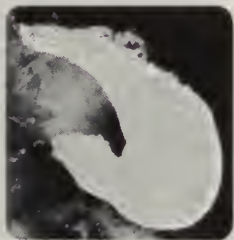
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In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism; coronary heart disease; congestive heart failure; cardiac arrhythmias; and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations, mydriasis, cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 mL (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

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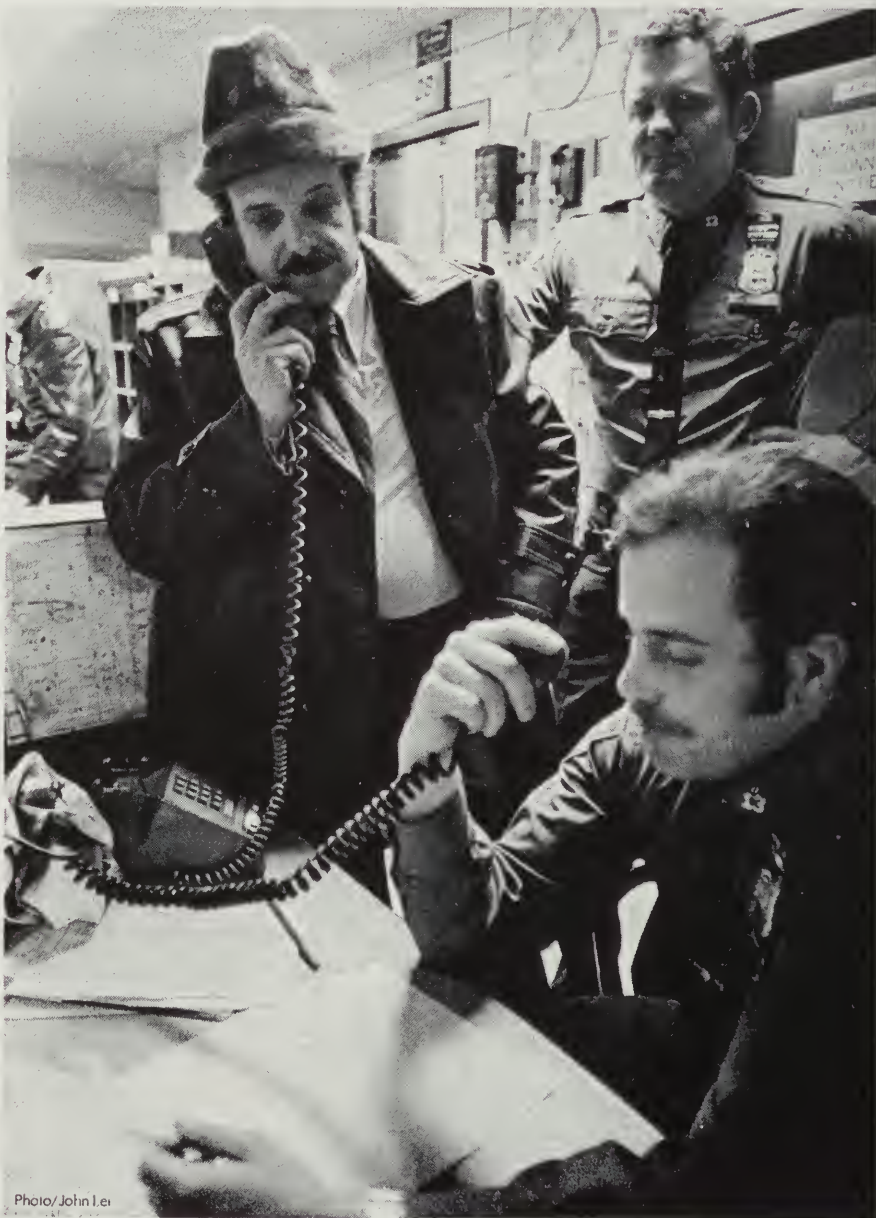
Lt. Edward Mamet was 37 when he lost his left leg in an accident three years ago. Everyone encouraged him to take his \$14,000 pension and retire, but he refused. He had

been on his way up, and he felt that if he retired he would just vegetate. He convinced his superiors to return him to duty, but out of concern for his safety they gave him a desk job. Paperwork was the last thing he wanted to do. With the help of the police surgeon, who declared him fit for active service, he was able to obtain a transfer. Soon after, he earned a promotion. Now he's supervising a team of 14 detectives and a sergeant, investigating unsolved crimes on the Lower East Side. He feels he does almost as well as before, and intends eventually to become a captain.

"I've chosen to perform," he says, "therefore I have to prove I can do it." He tests himself constantly. During New York's coldest and iciest winter in 90 years, he did not slip once.

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Skilled Orders Get Skilled Care

By FRED R. T. NELSON, MD and LEE ELIZABETH BRITTON, MA

Dr. Nelson is a graduate of the University of Maryland Medical School. He completed his Internship and Residency in orthopedic surgery at Bethesda Naval Medical Center, where he was Director of Training and Research in Orthopedics from 1972-1975. Dr. Nelson has been in private practice since 1975, and is a member of the medical staff of Suburban Hospital. He is a Clinical Instructor in Orthopedic Surgery at George Washington University, Medical Director of Manor Care of Adelphi Nursing Home and co-author of Manual of Orthopedic Terminology, which was recently released by C.B. Mosby.

Ms. Britton is Executive Director of the Montgomery County Medical Care Foundation. She received her Master of Arts degree in Sociology from the University of Maryland. Contact her for reprint and other data at Suite 202, 11141 Georgia Ave., Wheaton, MD 20902.

Abstract

Nursing homes have experienced significant advances in recent years. They now have the capacity to provide a wide range of skilled services, including nursing care, physical, occupational and speech therapy and social work services. The physician will obtain the full benefits of these services for his or her patients only if he or she clearly communicates the patient's previous condition, present needs and long-range goals.

Introduction

The authors have seen two common problems in the care of the nursing home patient. The first is the limited knowledge many physicians have of the services now provided in nursing homes, and our discussion will focus first on the types of services now available. The second problem we have seen is the poor communication between the physician, nurse, social worker and therapists concerning the patient's condition and prognosis. Being unaware of skilled services, complicated by poor communication, can lead to underutilization of nursing home services and personnel.

Perhaps it would be best to begin this discussion by briefly comparing long-term care institutions of 30 years ago with those of today. In the past, many homes were for residential care only. They may have provided support in the activities of daily living, and certain simple medications, but they generally did not provide skilled nursing care. In many instances, the staff in homes for the aged were not licensed professionals, had no special training in the care of the aged and provided supportive, rather than recuperative, care. The nursing home was therefore often seen as an institution for incurables.

This view was held by both the general population and also by the health professions, particularly physicians. There has been very little in the formal education of most physicians to change that outlook. Medical schools have only recently recognized the tremendous

amount of effort invested in the care of the elderly, and the need to educate new physicians—both in the means of delivering geriatric care and in the services available in the nursing home.

Types of Patients

The authors believe that nursing homes should be viewed as multipurpose facilities. Properly-staffed, they can care for a wide variety of patients, from the post-hospital patient who will eventually be discharged to home, to the senile patient who needs a supervised environment, to the terminal patient. The following section will discuss these different types of patients in more detail.

The nursing home is often a point of transition between hospital and home. For example, a patient who has experienced a hip fracture may need one-three weeks of hospital care for initial treatment and stabilization. Several more weeks of care in a skilled nursing facility may be needed to continue daily physical therapy and nursing observation. During the nursing home stay, the patient can regain the ability to perform the activities of daily living, and become independent once again.

The extended care facility can also represent a permanent place of residence. This does not necessarily mean that the individual has no potential for improvement and greater self-sufficiency. A period of intensive rehabilitative therapy may be necessary after admission to help the patient recover the skills necessary to bathe and dress, and to be able to go to the dining room independently. Ongoing maintenance therapy may also be necessary to keep the patient functioning with some independence. Even so, the intensive rehabilitative effort made after admission may reduce the care the patient needs later.

Finally, it should be recognized that there are patients for whom there will not be improvement. Obviously, this is true for severely and irreversibly senile individuals, and some who are terminally-ill. Severely senile individuals require constant supervision, which is available in a nursing home to assure that they eat regularly and maintain good hygiene. While many terminally-ill patients can be cared for at home, some cannot due to the type and method of administration of pain medications.

Types of Services

The physician must know what is available in today's nursing home if he or she is to meet the needs of the above types of patients. The average extended-care facility has social workers, registered and licensed prac-

tical nurses, physical therapists, occupational therapists, dieticians and speech therapists on its staff, either as employees or consultants.

The role of the social worker is the initial one in most homes and often involves a preadmission visit by relatives. The social worker reviews the patient's economic position and social history with the patient and/or family. This conference determines the patient's needs and preferences, and leads to plans for activities within the facility and to setting goals (such as ambulation and discharge).

Registered nurses play a crucial role in all of these institutions. These nurses could justifiably be called subspecialty nurses because of their experience in providing care to an older population. There are very few specialty training centers for these nurses. However, through extensive experience in caring for the aged, many have become skilled at seeing the signals of improvement or deterioration in each individual patient. They are able to assess the social, medical and personal factors that make the patient a more happy, productive and independent person, not only within the institution, but potentially within their own homes. The range of services varies depending on the size of the nursing staff. Some homes are able to provide such intensive services as respiratory care, IVs and management of patients in unstable conditions.

Registered nurses are responsible for numerous personnel who care for these patients, and, in particular, for nursing assistants. It is not uncommon to find that many nursing assistants also become skilled observers and are able to help patients benefit from the facility's program and reach their rehabilitation potential.

Physical therapists and physical therapy equipment are present in most of the institutions. As a part of the conditions for participation for Medicare, physical therapists must be treating the patient on a daily basis. As it turns out, they usually see patients five times a week. At a minimum, exercises on parallel bars, training in the use of crutches or a walker and whirlpool baths are available in the physical therapy department. Nursing homes with more extensive staff and equipment can provide intermittent cervical traction, pelvic traction, diathermy, high-frequency sound and other types of treatments. In order to meet Medicare skilled care requirements, physical therapy must be available on a five times per week basis.

Physical therapists are directly involved with assessing patients transferred from the hospital. They help in defining level of function at the time of admission and in predicting what progress the patient should make, in terms of their own professional experience. The physical therapist working within these institutions is aware of the long-term aspects of care, particularly when dealing with patients who have had strokes and major fractures. It is important to see the physical therapist as a member of the team, because without his/her help and assessment, changes in the patient might go unnoticed, and the patient's return to independence would be delayed. In the ideal setting, there is an interchange between the physical therapist, the nurse and the

physician. Unfortunately, it is rare for all three to be in the facility at the same time. This results in a loss of communication that leads to delay in modifying the patient's treatment plan, and is something that the physician should consider on the return visit to the long-term care facility.

Occupational therapists are increasingly important to long-term care facilities. The occupational therapist is too often thought of as somebody who helps the patient with basket weaving. Actually the occupational therapist is an extremely significant person, who is involved in assessing how the patient manages his/her own personal needs and how he/she functions in a group setting. The therapist also assesses the patient's potential for independence. The occupational therapy is directed at activities that will make patients satisfied with their placement in the institutional setting. Many persons arriving in a nursing home approach it with a negative outlook, feeling that their stay in the institution may become a permanent one. A good occupational therapist will help the patient find goals within the institution, make himself/herself useful, and take an active interest in his/her own physical improvement and well-being.

Again, the communication between the occupational therapist, the registered nurse and the physician is generally poor. Usually, the physical therapist and the occupational therapist communicate more frequently and easily with the registered nurse on the floor because they are the primarily involved members of the health-care delivery team. They are the ones who are in direct contact with the patient every day, whereas the physician sees the patient less often.

Speech therapy is generally available from visiting consultants, especially for those patients who have had strokes. Speech assessment is now becoming a diagnostic tool; it is used not only at the time of arrival in the extended-care facility, but also as an indication that physical, occupational and other therapies may also be indicated. The assessment on admission determines the patient's present level of functioning and potential for improvement. A treatment plan is then developed, and generally involves therapy from one to five times a week, either on an individual or group basis.

The speech therapist is also involved in a continuing reevaluation of the patient's condition. Improvements beyond what was expected may indicate that the patient has potential for improvement in other areas. Conversely, changes for the worse may indicate the development of a new medical problem, or of a psychological problem.

Getting Your Patient the Care You Want

The coordination of all of these services is under the direction of the physician, but in many instances, the daily responsibility is left with the nurse in charge of the unit on which the patient resides. This is a key point that should be remembered by the physician, who should communicate the care plans clearly to the nurse.

The main failure that occurs in the treatment of patients in skilled nursing facilities lies in the transmission of information about the patient. The information known only to the physician is often the most important material. The facility staff is particularly interested in the patient's condition prior to the current illness. Questions that might be considered would be: was the patient independent and able to take care of himself without difficulty; if he was living with someone else, how independent was he of that other person; if he was dependent on other persons, for what kind of assistance, and is it a setting to which the patient could successfully return? A second important factor is the patient's ambulatory status prior to the hospitalization. Often one discovers that while s/he was ambulatory, s/he already was having difficulty and was using a walker, cane or some other appliance. Often where patients were previously institutionalized, it is found that they were only minimally independent in their ambulation at the time of their acute episode.

With no antecedent health information, it is often difficult for the facility staff to evaluate changes which have occurred in a patient while s/he was hospitalized. During the course of the hospitalization, a patient may become either more independent, or less so. What is important to the person receiving the patient in the skilled nursing facility is to know how the independence, ambulatory skills and alertness of this individual have been affected by the present illness and hospitalization. Equally important is how it is likely to be affected on a long-term basis. Often the patient is admitted to a skilled nursing facility with absolutely no record of what his/her prospects for improvement are, and is left in the care of a person who has not previously seen the patient. The time of transfer is particularly difficult for many patients, and their level of alertness may change. It is not uncommon to see a patient doing fairly well with physical therapy in the hospital setting, and then suddenly not do very well in the nursing home. If there is no statement as to previous status and potential for improvement, it is quite possible that this reduced level of ability becomes expected of that patient and his/her recovery remains retarded.

It follows that a full plan of care requires continuous updating. It should be indicated in the progress notes whether the patient is fulfilling (or even exceeding) the expectations of the physician and comparing his/her condition in the hospital to his/her condition in the skilled nursing care facility. The condition of the patient obviously varies from day to day and could influence the assessment depending on the time of the physician's visits. Therefore, the information obtained from the occupational therapists, physical therapists and nurses during the stay in the skilled care facility is vitally important to the physician in understanding the fluctuations in the patient's progress. The physician is generally not in daily attendance to the patient and may not be seeing him more often than once a month. If the patient with potential is not improving, the physician and facility staff must take into account all the variables which can slow progress, such as age, pre-existing infirmities, emboli, congestive heart failure and

advancing senility, to name a few.

This article should alert the physician to the need for a different approach to the management of long-term care patients. The physician must become aware of the services different nursing facilities provide and develop a care plan that uses those services to the best advantage. S/he must also inform the staff of the patient's previous level of independence and what can be expected in the future. Finally, s/he must discuss changes in the patient's condition with the staff, and modify the care plan when changes occur.

This is the only way to assure that the patient receives the type of care s/he needs. ☐

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181st ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

MAY 2-5, 1979

Hunt Valley Inn, Hunt Valley, MD

*Among the topics and speakers at the Annual Meeting are:

WEDNESDAY, MAY 2

MARYLAND SOCIETY OF ALLERGY: "Adverse Reactions to Radiographic Contrast Media." Burton Zwelman, MD, Phila., PA

MARYLAND ORTHOPEDIC SOCIETY: "Arthritis and the Role of Total Joint Replacement," David Hungerford, MD, Baltimore

HOSPITAL-AFFILIATED PHYSICIANS COMMITTEE: Seminar on Negotiations, "Dynamics of Conflict Resolution," Mr. J. Paige Clousson, AMA, Chicago

MARYLAND RADIOLOGICAL SOCIETY: "Computed Tomography of the Body 1979," Stanley S. Siegelman, MD, Baltimore

MARYLAND PSYCHIATRIC SOCIETY: "Teenage Pregnancies," Felix Heald, MD, Baltimore

Other Wednesday program participants are:

Maryland Ophthalmological Society
American College of Surgeons, Maryland Chapter

THURSDAY, MAY 3

MARYLAND DERMATOLOGICAL SOCIETY: "Sexually-Transmitted Diseases," John M. Knox, MD, Houston, TX

MARYLAND SOCIETY OF CARDIOLOGY: "Exercise: Pain or Panacea?" Samuel Fox, III, MD, Washington, DC/"Stress Testing: Who Should Have It?," Nicholas J. Fortuin, MD, Baltimore

MARYLAND UROLOGICAL SOCIETY: "Seminar on Urinary Tract Infection - Current Concepts." Bruce W. Berger, MD; Edward W. Campbell, Jr., MD; Michael J. Droller, MD, Baltimore

COMMITTEE ON ALCOHOLISM, MED-CHI: "Alcoholism in the Born and Unborn," Stanley Gitlow, MD, New York City, NY. "Fetal Alcohol Syndrome," Charles Whitfield, MD, Baltimore. Moderator: John H. Hirschfeld, MD, Baltimore

JOHN STAIGE DAVIS SOCIETY OF PLASTIC SURGEONS OF MARYLAND: "Myocutaneous Flap." John P. McCraw, MD, Norfolk, VA

COMMITTEE ON PREVENTIVE MEDICINE AND PUBLIC HEALTH, AND SUBCOMMITTEE ON INFECTIOUS DISEASES, MED-CHI: "Use and Abuse of Antibiotics," Michael L. Levin, MD and Clayton Moravec, MD, Baltimore

MARYLAND SOCIETY OF INTERNAL MEDICINE: "The Expanding Use of Computers in Office Practice." Speaker to be announced.

AMERICAN ACADEMY OF FAMILY PHYSICIANS: "Plenary Session on Prospective Medicine," John W. Williamson, MD, Baltimore; Paul C. Brucker, MD, Philadelphia, PA; and Ross Egger, MD, Muncie, IN

Other Thursday program participants are:

Joint Meeting: Maryland Industrial Medical Association/Committee on Occupational Health, Med-CHI

FRIDAY, MAY 4

COGGINS LECTURE ON GERIATRICS: "Essentials in Care of the Elderly," William Reichel, MD, Baltimore

GENETICS PROGRAM: Faculty of Johns Hopkins. Specific topics and speakers to be announced.

MARYLAND STATEWIDE PSRO COUNCIL: "PSRO and its Effect on Your Practice," John Bussman, MD, Portland, OR;

Emidio A. Bianco, MD, Baltimore; Mr. John J. Kent, Jr., Baltimore

OBSTETRICAL AND GYNECOLOGICAL SOCIETY OF MARYLAND: "The Health Care Delivery System in Obstetrics and Gynecology, Present and Future," Irving Kushner, MD

MARYLAND SOCIETY OF PATHOLOGISTS: Topic to be announced. Elaine Jaffee, MD, Bethesda

JOINT MEETING: COMMITTEES ON PHYSICIAN REHABILITATION AND PEER REVIEW, MED-CHI, COMMISSION ON MEDICAL DISCIPLINE, STATE OF MARYLAND: "Seminar on the Impaired Physician." Speakers to be announced.

DEPARTMENT OF FAMILY PRACTICE, UNIVERSITY OF MARYLAND HOSPITAL: "Medical Records for Continuity of Patient Care." Speaker to be announced.

MARYLAND-DC SOCIETY OF ANESTHESIOLOGISTS: Topic and speaker to be announced.

MARYLAND SOCIETY OF OTOLARYNGOLOGY: "Speech Disorders." Speakers to be announced.

MARYLAND SOCIETY OF NUCLEAR MEDICINE: "Recent Advances in Clinical Nuclear Medicine," Gerald S. Freedman, MD, New Haven, CT

KRESS MEMORIAL LECTURE: "The Pulmonary Manifestations of Collagen-Vascular Diseases," Allen R. Myers, MD, Philadelphia, PA

MARYLAND SOCIETY OF REHABILITATION MEDICINE: "Current Office Diagnosis and Management of Musculoskeletal Pain Syndrome," Lionel A. Wolpin, MD, Los Angeles

Other Friday program participants are:

American Academy of Pediatrics, Maryland Chapter
American College of Emergency Physicians, Maryland Chapter
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*Topics subject to change. Please consult Advance and Final Programs for more current information.

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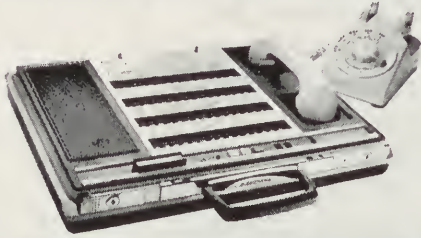
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Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.

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Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age, known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL. Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE. To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

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Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE. Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic; have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

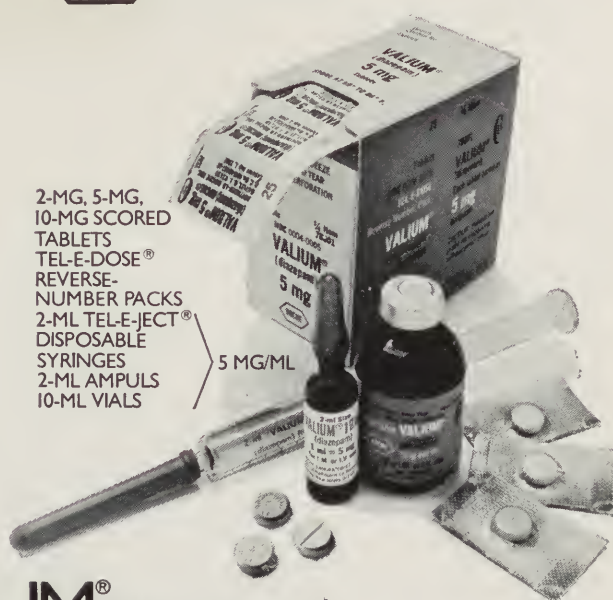
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

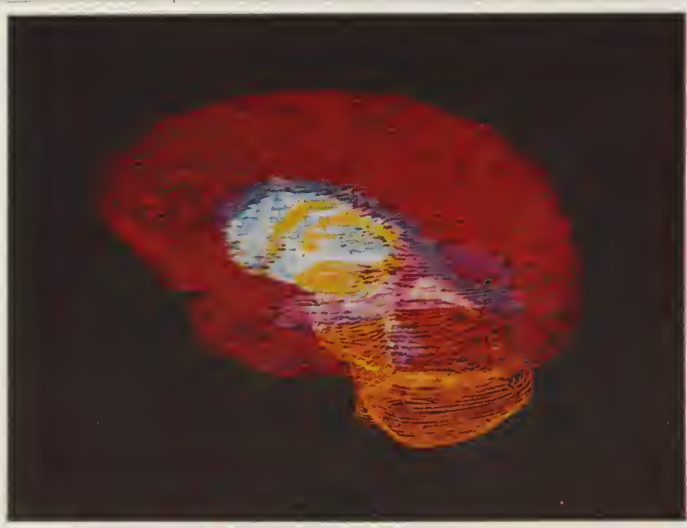
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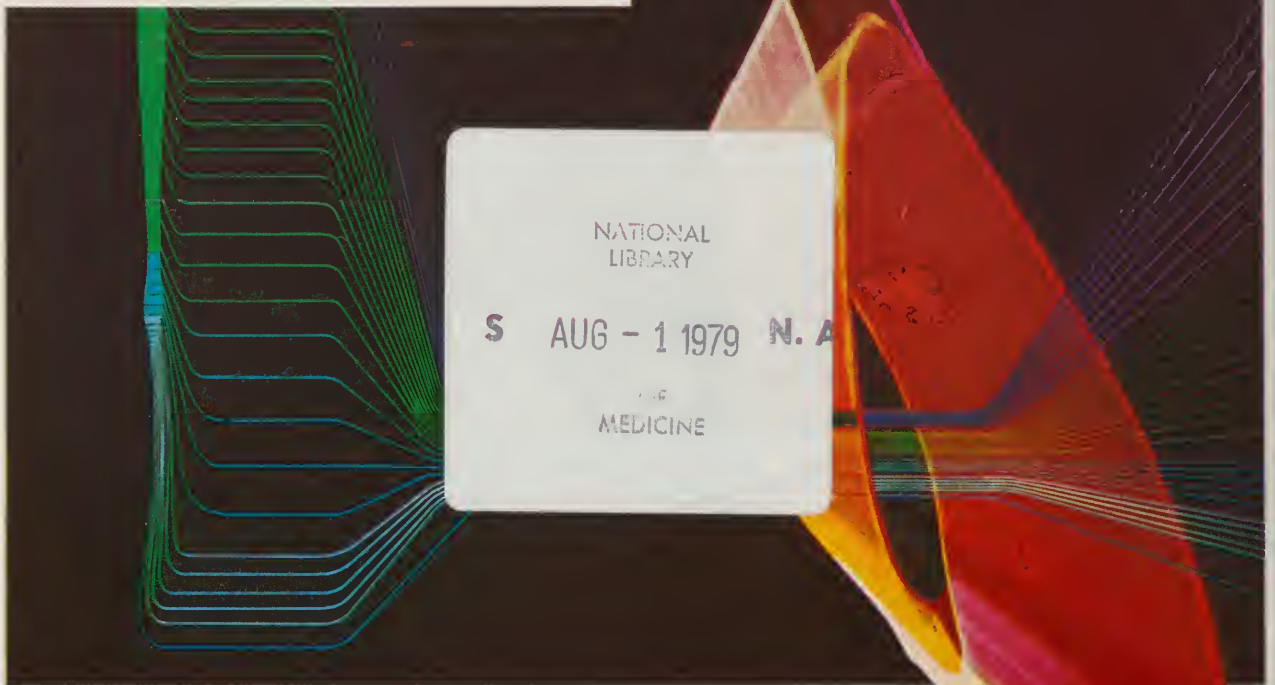
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ACUTE MOUNTAIN SICKNESS

by Faculty Librarian

Joseph E. Jensen page 27

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The Physician's Role in Narcotic Abuse, by Kennard L. Yaffe, MD

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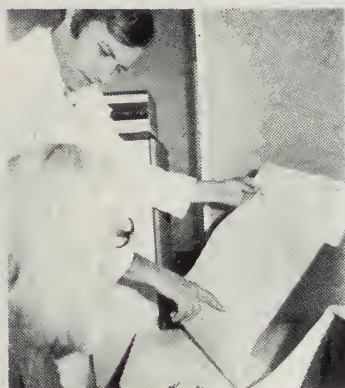
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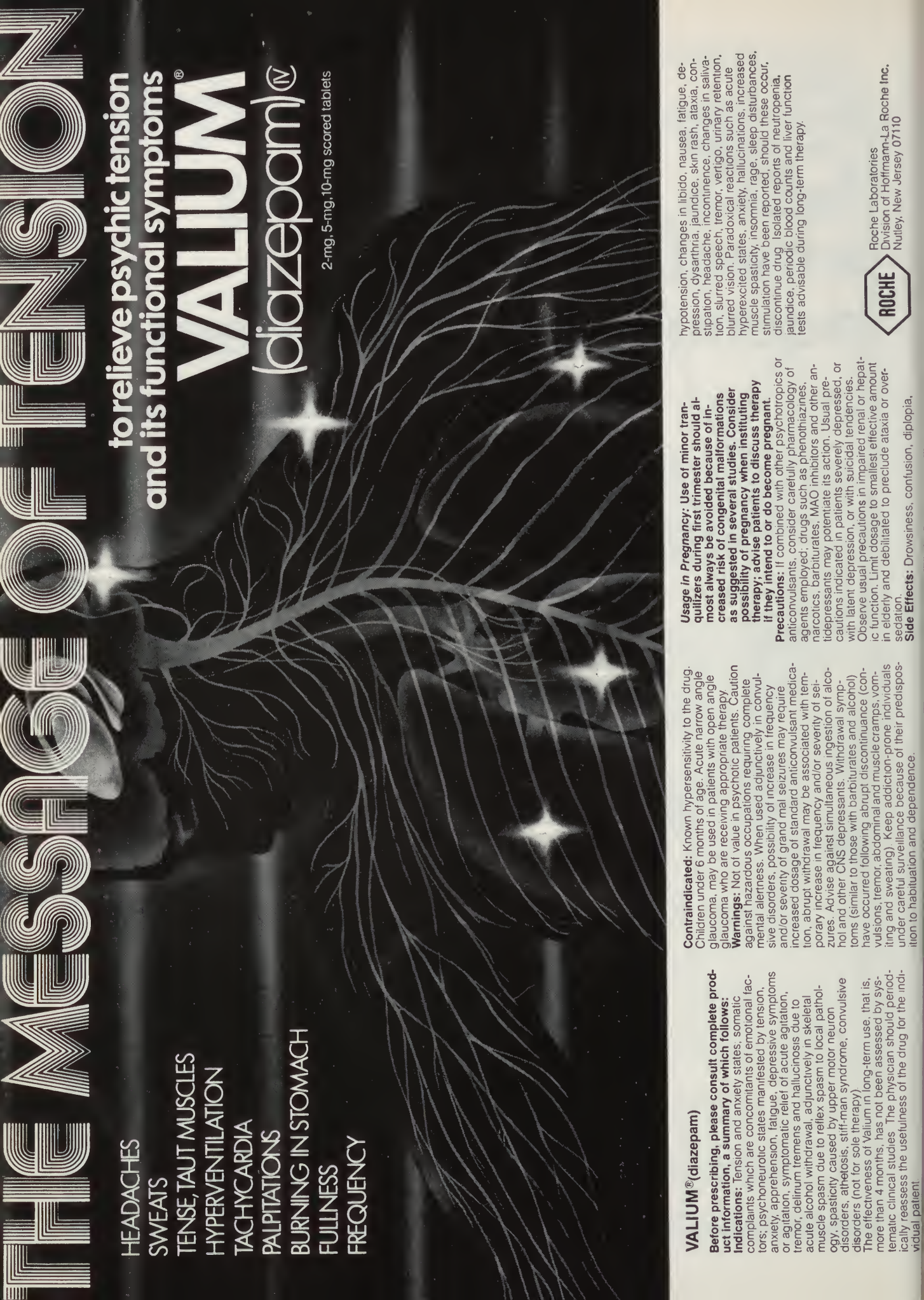
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma, who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjuvantly in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia,

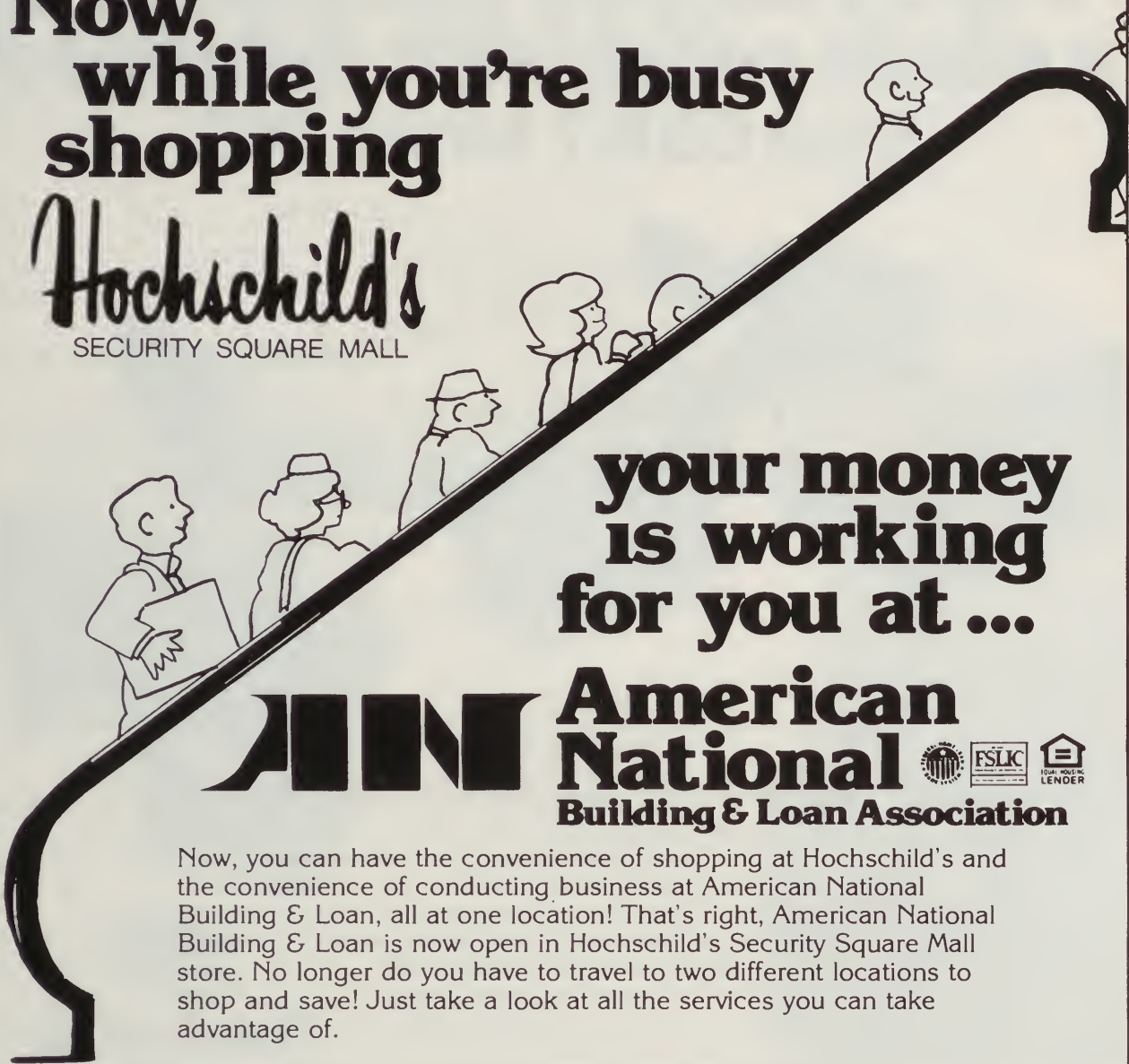
hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neuroleptic jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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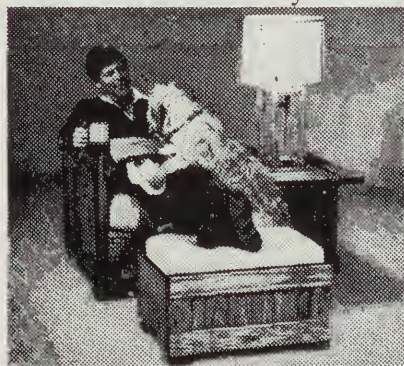
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MARCH, 1979

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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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THIS IS JOSEPH JENSEN, the Faculty's mild-mannered but energetic Librarian, "working" a wall at Great Falls, VA. His article on acute mountain sickness appears on p. 27 in this issue. (Photograph by Robert Ryan.)

The Cover: Bobbi Jensen on Quandary Peak, central Colorado, January, 1977. (Photo by Joseph Jensen.)

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
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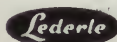
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Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N. Y. 1969.



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The Open Forum

Again: Hapsburg or Habsburg?

To the Editor:

I agree 100% with Dr. Steingaszner's comment about the distortion of the Habsburg dynasty's family name, which is spelled correctly in European countries, but is misspelled in English-speaking countries. Your analogy of Czar and Tsar is erroneous. You are not taking into consideration that in "Cyrilica," written Russian words transformed into the Latin alphabet will sound differently in different languages according to different pronunciation.


ANDRE V. FESUS, MD, PA
Pravia Med. Ctr.
413 Commonwealth Ave.,
Balto., MD 21228.

(*Managing Editor's Note:* Dr. Fesus refers to the Open Forum letter of Dr. Laszlo C. Steingaszner of Woodbridge, VA, published in the November, 1978 issue concerning the spelling of the name of the former Austrian ruling dynasty, contained in the article **Health in History—"Bertie": Britain's King Edward VII** (September, 1978.) As I replied to Dr. Steingaszner's letter, "The spelling of the family name appears both ways, depending on which article or reference work one consults," and I still stand by that position. On the other hand, after having talked with several German and Austrian-born authorities concerning this, I also believe

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that Dr. Fesus' point is well-taken: "... is spelled correctly in European countries, but is misspelled in English-speaking countries." My articles are primarily researched from English-language sources, and are written almost entirely in English, with foreign terms used where appropriate. In future, however, I shall refer only to Habsburgs—with a "b."—BT.) ☐

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Practical Advice on Patients Receiving Nasal Applicator Radiotherapy

(A Joint Statement from the Maryland ENT Society, the Department of Otolaryngology, the Johns Hopkins Hospital and the University of Maryland)

Through recent publicity, the association of radiotherapy to the head and region and cancer of the thyroid has become a common concern. There is, indeed, an increased risk in those patients who had such "X-ray treatment" to develop tumors of the thyroid. In the Maryland region, however, there were two different forms of radiotherapy given. The first was the external beam therapy, or where the patient was put in front of a machine. Treatments of this type were generally given for such conditions as an enlarged thymus gland, acne, enlarged adenoids, tonsillitis and ringworm of the scalp. It is this form of radiotherapy that has been associated with thyroid cancer. The manner in which these patients should be handled has been well-outlined in the statement of the Medical and Chirurgical Faculty of the State of Maryland as of Jan. 12, 1977.

The second form of radiotherapy which was commonly used was the nasopharyngeal applicator. This therapy consisted of small metal rods put in the nose, and was useful in treating some forms of hearing loss. This latter form of treatment using the "radium applicator" has not been implicated to date in thyroid cancer or other neoplasia. We, therefore, feel it is important to differentiate the risks of the two forms of therapy. It is the general opinion that anyone exposed to any form of radiotherapy for benign conditions is potentially at risk; however, the patients who received nasopharyngeal applicators need not be handled in the same way as those given external beam therapy. Where doubt exists in a particular patient as to which form of therapy was used, one must assume that the external treatments were employed.

A retrospective study is being started in order to evaluate patients who underwent applicator therapy. This study should assist us in administering care to this group in the future. At the present time, however, we feel that no recall of such patients is necessary. In the case of those patients who present themselves for examination, having received nasal applicator treatments, a complete head and neck examination should be performed including nasopharyngeal examination, as well as palpation of the salivary glands and thyroid.

The need for follow-up examination can be determined by the individual physician at that time. ☐

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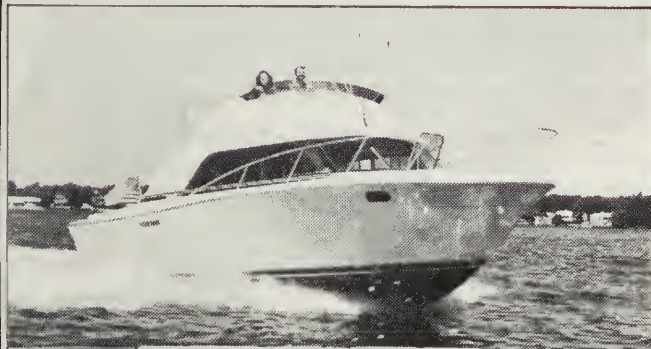
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Executive Committee

The Executive Committee met on Jan. 11, 1979 and took the following actions:

1. Received a delegation from the Program and Arrangements Committee to discuss site locations for Faculty Semiannual Meetings and advised these representatives that the Committee had authority to recommend sites to the Council for Semiannual Meeting locations; also, that it could invite the incoming member of the Committee to attend Committee meetings prior to formal commencement of his term on the Committee.

The Executive Committee in response to requests from this group referred the following to the Policy and Planning Committee for consideration and recommendation:



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1. Determination as to whether or not the Faculty's Semiannual sessions should be held out of state or stay within the geographical confines of Maryland or be held only within a certain defined area outside of Maryland.

2. Determine the manner in which such sites should be selected, if they are to be held outside of the State of Maryland and the manner of underwriting costs for this activity.

3. Determine the appropriate method of handling the arrangements after the site is selected and approved by the Council, that is either through the services of a travel agent or through negotiations by staff or the appropriate Faculty committee.

4. Coordination of trips with Component Society activities as well as pleasure travel offered Faculty members at no cost to the Faculty.

5. Approved the budget for recommendation to the Council for the 1979 calendar year, recognizing a budget deficit which would be funded from Faculty reserves.

6. Referred to the Policy and Planning Committee the question of means of financing any future budgetary deficits that may occur with the understanding that any precipitous dues increase should be avoided.

7. Approved having two Faculty members meet with Auxiliary counterparts for the purpose of discussing what, if anything, can be done in connection with family relations of members.

8. Heard a request from the Maryland Chapter of the American College of Emergency Physicians that consideration be given to designation of one of its members to serve on some Blue Shield committee.

9. Approved participation in a study currently planned on Hospital In-patient Quality of Care as a joint venture with the Maryland Hospital Association.

The following were selected to serve in this capacity:

David Solomon, MD, Baltimore City

Watson P. Kime, MD, Baltimore City

David S. McHold, MD, Annapolis

10. Approved nominees for Council action for possible appointment to the Maryland Blue Shield Board and committees of Blue Shield.

11. Adopted an addition to personnel policies dealing with reimbursement for meals of staff while on Faculty business.

12. Authorized the Council Chairman to meet with interested parties to review various regulations dealing with nurse roles in the practice of medicine and to develop testimony on these proposals for the public hearing or move in a legal manner if that is appropriate.

13. Heard that the State Health Planning Agency is moving ahead with Appropriateness Review of Institutional Facilities and approved appointment of various physicians to committees working on this activity.

14. Approved expenditure of funds from the CME Committee dedicated fund to provide for membership on the National Council of State Committees on CME.

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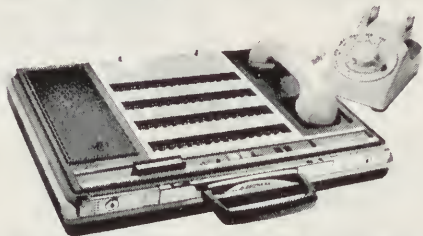
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Executive Director's Newsletter

March, 1979

TWO Two physicians have won national awards in the 1978 AMA
National Contest for Medical Society Speakers Bureaus.

WINNERS

Raymond J. Donovan, MD, Baltimore, won first place in the
Radio Talk Show category, and J. Roy Guyther, MD, Mechanics-
ville, won second place in the professional audience category.

MARYLAND

The Faculty receives \$1,000.00 cash as a result of Dr.
Donovan's prize and \$500.00 as a result of Dr. Guyther's
award. Both contestants receive an appropriate trophy.

The awards were made during the AMA National Leadership Con-
ference in Chicago in February.

YOU ARE

Frequently, physicians will indicate that the Component
Medical Society or the Faculty, to which they belong, is a
separate entity and they have no connection with either of
these two groups when policies are enunciated one way or the
other.

THE

MEDICAL

SOCIETY

This is particularly true during legislative sessions at the
General Assembly, when we find physicians, on occasion, taking
a different position and campaigning actively against the
Faculty's position on a particular issue.

The medical society, at a local or state (and also national)
level is the physician — if your position disagrees with that
of the formal group, it is not necessarily bad. However, we
urge that prior to speaking out, all the facts on the position
taken by any of the groups be obtained.

And, remember, the medical society's position is determined
by physicians who speak on your behalf. Participation by
individuals is important so that all points of view are
considered.

CERTIFICATE

OF NEED

IN PRIVATE

OFFICES

The Faculty has been successful to date in defeating legis-
lation that would extend the Certificate of Need statute in
Maryland to include physicians' offices when equipment ex-
ceeds \$150,000.00 in amount. However, recently the State
Health Coordinating Council went on record as supporting
legislation on a federal level that would include such a
provision.

While hearings are not scheduled as yet on the National Health
Planning Act of 1979, this will undoubtedly be included when
such is introduced. Members are alerted to this issue at this
time, however, for potential future action.

RESOLUTIONS Deadline date for receipt of resolutions for consideration
at the Annual House of Delegates session is Friday, March 9,
DEADLINE 1979. At the time of this writing, no resolutions have
been received.

NOMINATIONS Component medical societies have been solicited for (a)
nominees from which the president will select members of
FOR the Nominating Committee, and (b) nominees for consideration
of the Nominating Committee, when appointed, for submission
FACULTY to the House of Delegates.

POSTS Full details can be obtained from component society officials
or from the Faculty office.

 The deadline for receipt of nominees for the consideration
of the Nominating Committee is Friday, March 16, 1979.

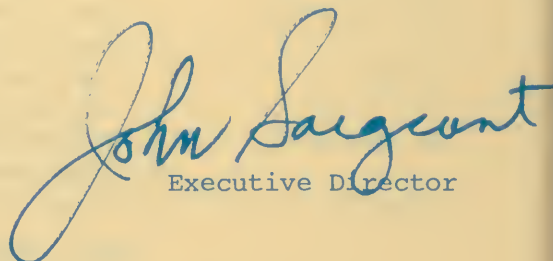
MEMO A request has recently been received from the Maryland Board
of Pharmacy that physicians note specific directions on
FROM medication labels rather than "Take as directed." The
reason for this is that patients often forget directions,
DRUG and those who care for geriatric patients often get a con-
fused idea from the patients as to what the original direc-
COMMITTEE tions were. The Faculty's Committee on Drugs solicits your
cooperation.

LEGISLATIVE The Faculty is again operating a Legislative Hotline to
keep you informed of legislative activity on a current
HOTLINE basis. The toll-free number from anywhere in Maryland and
the District of Columbia is:

1-800-492-9373.

If you wish specifics on any item involving legislation,
contact should be made with the Faculty office at
(301) 539-0872. Those directly involved in legislation are:

John Sargeant
Elza Davis.


Executive Director

IMPAIRED PHYSICIAN'S HOTLINE (301) 467-4224

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181st ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

MAY 2-5, 1979

Hunt Valley Inn, Hunt Valley, MD

REGISTRATION

The Registration Desk is located in the rear of the Exhibit Hall, (Valley Ballroom), Lower Level and will be open:

Wednesday: 8:30-4:30 PM

Thursday: 8:30-4:30 PM

Friday: 8:30-3:30 PM

ALL ATTENDEES MUST REGISTER AND RECEIVE A BADGE to gain admission to the meeting rooms and Exhibit Hall.

House of Delegates Registration:

House of Delegates Registration is located outside Maryland Rooms III and IV and will be open:

Wednesday: 8:30-9:30 AM

Saturday: 8-9 AM

House of Delegates members in attendance on Wednesday must register both at the General Registration Desk and at the House of Delegates Meeting.

Preregistration:

IF YOU HAVE MADE RESERVATIONS FOR THE MEAL FUNCTIONS, YOU ARE PREREGISTERED FOR THE MEETING. PLEASE PICK UP YOUR REGISTRATION PACKET, WHICH WILL INCLUDE YOUR BADGE AND ALL TICKETS, AT THE ADVANCE REGISTRATION DESK IN THE REAR OF THE EXHIBIT HALL.

BUSINESS SESSIONS

The first meeting of the House of Delegates will be held **Wednesday, May 2, 9:30 AM** in Maryland Rooms III and IV.

The **Reference Committee** will hold a meeting at which any members may speak on the Resolutions and Reference Committee Reports that come before the House on Sat., May 5. The Reference Committee will meet on **Thursday, May 3, approximately 4:50 PM**, (immediately following the General Membership Meeting) in Maryland Rooms I-IV.

The second meeting of the House of Delegates will be held **Sat., May 5, 9 AM**, in Maryland Rooms III and IV.

General Membership Meeting:

In accordance with Article 5 of the Bylaws, a General Meeting of the Faculty will be held on **Thurs., May 3, at 4 PM** in Maryland Rooms I-IV.

SCIENTIFIC SESSIONS

The scientific sessions will be held:

Wednesday: 2-5 PM

Thursday: 9 AM-5 PM

Friday: 9 AM-5 PM*

*Please note that scientific sessions will be held Friday morning and Friday afternoon.

EXHIBITS

Exhibits will be open:

Wednesday: 9 AM-5 PM

Thursday: 9 AM-5 PM

Friday: 9 AM-12 NOON

Exhibitors' Sweepstakes

Physicians will become eligible for 1st and 2nd place prizes of **\$500 cash and \$200 cash** by visiting a minimum of 25 technical exhibitors. **Drawing will be held on Fri., May 4, 12:15 PM, in the Exhibit Hall.** Rules and regulations governing this competition will be available at the Registration Desk.

HEALTH EVALUATION TESTS

HET's will be performed in the Garden Room:

Wednesday: 8:30 AM-4:30 PM

Thursday: 8:30 AM-4:30 PM

Charge will be \$12. Preregistration not required.

CONTINUING MEDICAL EDUCATION CREDITS

Category I credits are awarded on an hour-for-hour basis for all scientific sessions at this meeting, including the Prayer Breakfast, the Lunch and Learn Session and Meet the Speaker. The scientific program is acceptable for Category I credit hours for the AMA Physician's Recognition Award, and required credit hours for Continuing Medical Education by the Maryland State Board of Medical Examiners. Prescribed credit hours have been applied for from the American Academy of Family Physicians.

The number of credit hours awarded for each session is listed in parenthesis following the description of the session, e.g. (1.5 hrs.). A total of 18 hrs. is available for the Annual Meeting program.

RESERVATIONS

**TICKETS WILL NOT BE MAILED
TICKETS FOR ALL FUNCTIONS ARE
TO BE PICKED UP AT
ADVANCE REGISTRATION DESK IN
REAR OF EXHIBIT HALL**

AUXILIARY ACTIVITIES

A dinner and square dance, cosponsored by the Auxiliary, will be held **Thurs., May 3. No Host Bar: 6:30 PM, Dinner and Square Dance: 7:30-11 PM.** The general meeting will be held on **Fri., May 4, 10 AM**, followed by cocktails and **luncheon** beginning at **NOON.** Auxiliary functions are open to Auxiliary members, their guests and all physicians' spouses.

Everyone is invited to attend. Additional information given at back of program under "MEAL FUNCTIONS AND SOCIAL ACTIVITIES."

Reservations required. Use reservation form at back of this program.

Francis C. Mayle, MD, President

Edward F. Cotter, MD, Chairman Committee on Program and Arrangements

DAILY CONCURRENT SESSIONS COSPONSORED BY MARYLAND SOCIETIES, VOLUNTARY HEALTH ORGANIZATIONS AND COMMITTEES OF THE FACULTY

WEDNESDAY, MAY 2

Concurrent Sessions

**9 AM/MARYLAND ROOMS III AND IV
COUNCIL MEETING**

**9:30 AM/MARYLAND ROOMS III AND IV
HOUSE OF DELEGATES MEETING**

**12:15 PM/HUNT ROOM
MARYLAND MEDICAL POLITICAL ACTION COMMITTEE LUNCHEON**

Topic and Speaker to be announced.

Reservations required. Use reservation form at back of this program.

**2 PM/MARYLAND ROOMS I AND II
MARYLAND RADIOLOGICAL SOCIETY**

Computed Tomography of the Body 1979

Stanley S. Siegelman, MD, Baltimore (1.5 hrs.)

**2 PM/MARYLAND ROOMS III AND IV
AMERICAN COLLEGE OF SURGEONS, MARYLAND CHAPTER**

Topics and Speakers to be announced. (3 hrs.)

**2 PM/PARLOR A
MARYLAND PSYCHIATRIC SOCIETY**

Adolescent Pregnancies

Felix P. Heald, MD, Baltimore (1.5 hrs.)

**2 PM/PARLORS C AND D
MARYLAND SOCIETY OF ALLERGY**

Allergy Diagnosis by RAST

Philip S. Norman, MD, Baltimore

Allergic Reaction to Radiographic Contrast Media

Burton Zweiman, MD, Philadelphia, PA (1.5 hrs.)

**2:30 PM/KING'S PLEASURE ROOM
HOSPITAL-AFFILIATED PHYSICIANS COMMITTEE**

SEMINAR ON NEGOTIATIONS-Dynamics of Conflict Resolution

J. Paige Clousson, JD, Chicago, IL (1.5 hrs.)

**3:30 PM/MARYLAND ROOMS I AND II
MARYLAND OPHTHALMOLOGICAL SOCIETY**

Moderator: **Allan D. Jensen, MD, Baltimore**

Diagnosis and Management of Carotid Occlusive Disease, the Role of Ocular Signs and Symptoms

Neil R. Miller, MD, Baltimore

Glaucoma Medications—Systemic Side Effects

R. D. Richards, MD, Baltimore

Symptoms of Significant Retinal Disease

Robert Liss, MD, Baltimore

Topics to be announced in Final Program.

Stuart Dankner, MD, Baltimore

James Kelley, MD, Baltimore (1.5 hrs.)

**3:30 PM/PARLOR A
MARYLAND ORTHOPEDIC SOCIETY**

The Role of Total Joint Replacement in the Management of Arthritis

David S. Hungerford, MD, Baltimore

Kenneth Krackow, MD, Baltimore (1.5 hrs.)

**5:30 PM/HUNT ROOM
HOSPITALITY NIGHT**

Complimentary Social Hour for members, exhibitors and invited guests.

Reservations required. Use reservation form at back of program.

THURSDAY, MAY 3

CONCURRENT SESSIONS

**7:30 AM/HUNT ROOM
PRAYER BREAKFAST**

What Hath Man Wrought?

Reverend Clyde R. Shallenberger

Director, Chaplaincy Service, Johns Hopkins Hospital, Baltimore

Representatives will deliver brief readings from the following religions:

Buddhism—Krita Apibunyopes, MD

Christian—J. Courtland Robinson, MD

Hindu—Belur S. Bhagavan, MD

Islam—Gholam R. Sadjadi, MD

Jewish—Ira A. Morris, MD

Muslem—Misbah Khan, MD

Reservations required. Use reservation form at back of this program. (1 hr.)

**9 AM/MARYLAND ROOMS I AND II
MARYLAND SOCIETY OF INTERNAL MEDICINE**

The Expanding Use of Computers in Office Practice

Speaker to be announced. (1.5 hrs.)

**9 AM/MARYLAND ROOM III
MARYLAND UROLOGICAL SOCIETY**

URINARY TRACT INFECTIONS—CURRENT CONCEPTS

Etiology of Urinary Tract Infection in Females

Michael J. Droller, MD, Baltimore

Topics to be announced in Final Program

Bruce W. Berger, MD, Baltimore

Edward W. Campbell, Jr., MD, Baltimore (1.5 hrs.)

**9 AM/MARYLAND ROOM IV
OCCUPATIONAL HEALTH COMMITTEE, MED-CHI
and MARYLAND INDUSTRIAL MEDICAL ASSOCIATION**

Approach to Occupational Lung Disease

Stuart Brooks, MD, Cincinnati, OH

Occupational Skin Disease

Edward A. Emmet, MD, MS, Baltimore (1.5 hrs.)

9 AM/PARLOR A

OFFICE ON AGING, STATE OF MARYLAND

Epidemiology of Disability Among the Aged in Rural Maryland

Matthew Tayback, ScD, Baltimore (1.5 hrs.)

9 AM/PARLORS C AND D

SUBCOMMITTEE ON INFECTIOUS DISEASES/COMMITTEE ON PREVENTIVE MEDICINE AND PUBLIC HEALTH, MED-CHI

The Use and Abuse of Antibiotics
Michael L. Levin, MD, Baltimore
Clayton L. Moravec, MD, Baltimore
Stephen Schimf, MD, Baltimore

(1.5 hrs.)

10:30 AM/MARYLAND ROOMS I AND II
MARYLAND DERMATOLOGICAL SOCIETY

Sexually-Transmitted Diseases
John M. Knox, MD, Houston, TX

(1.5 hrs.)

10:30 AM/MARYLAND ROOM III
MARYLAND SOCIETY OF CARDIOLOGY

Exercise: Pain or Panacea?
 Speaker to be announced

Stress Testing: Who Should Have It?
Nicholas J. Fortuin, MD, Baltimore

(1.5 hrs.)

10:30 AM/MARYLAND ROOM IV
COMMITTEE ON ALCOHOLISM, MED-CHI
 Moderator: **John H. Hirschfeld, MD, Baltimore**

The Pharmacological Basis of Alcoholism
Stanley E. Gitlow, MD, New York, NY

Fetal Alcohol Syndrome
Charles L. Whitfield, MD, Baltimore

(1.5 hrs.)

10:30 AM/Parlor A
THE JOHN STAIGE DAVIS SOCIETY OF PLASTIC
SURGEONS OF MARYLAND

New Techniques for Soft Tissue
Replacement—Myocutaneous Flap
John B. McCraw, MD, Norfolk, VA

(1.5 hrs.)

12:15 PM/MARYLAND ROOMS I AND II
ELECTION OF THE BOARD OF MEDICAL EXAMINERS

12:15 PM/HUNT ROOM
LUNCH AND LEARN SESSION

(1.5 hrs.)

Detailed information on each table listed elsewhere in this program. **Preregistration required.** Use reservation form at back of this program.

2 PM/MARYLAND ROOMS I-IV
ACADEMY OF FAMILY PHYSICIANS, MARYLAND CHAPTER

PLENARY SESSION ON PROSPECTIVE MEDICINE

Moderator: **J. Roy Guyther, MD, Mechanicsville**

Panel Participants:

Health Hazard Appraisal:
Reflections and Critique
John W. Williamson, MD, Baltimore

Techniques of Health Hazard Appraisal
Paul C. Brucker, MD, Philadelphia, PA

How to Utilize Prospective Medicine in Daily Practice
Ross Egger, MD, Muncie, IN

(2 hrs.)

4 PM/MARYLAND ROOMS I-IV
GENERAL MEMBERSHIP MEETING

In accordance with Article 5 of the Bylaws, a General Meeting of the Faculty will be held.

All members of the Faculty are invited to attend.

REFERENCE COMMITTEE MEETING

immediately following General Membership Meeting. Any member may speak on the Resolutions and Reference Committee Report that comes before the House of Delegates on Sat., May 5.

6:30 PM/MARYLAND ROOMS I-IV
DINNER AND SQUARE DANCE

6:30 PM — NO HOST BAR

7:30 PM — DINNER

8:30 PM — SQUARE DANCE

Cosponsored by the Auxiliary to BENEFIT AMA-ERF. **Reservations required.** Use reservation form at back of this program.

FRIDAY,
MAY 4

CONCURRENT SESSIONS

9 AM/MARYLAND ROOMS III AND IV
AMERICAN HEART ASSOCIATION,
MARYLAND AFFILIATE, INC.

HYPERTENSION IN MARYLAND: WHAT
WE HAVE ACCOMPLISHED AND WHAT
REMAINS TO BE DONE

Household Survey
Aristide Apostolides, PhD, Baltimore
George Entwisle, MD, Baltimore

What's New in Hypertension?
Edward Freis, MD, Wash., DC (3 hrs.)

9 AM/GARDEN ROOM
MARYLAND-DC SOCIETY OF ANESTHESIOLOGISTS

Local Anesthetics
 Speaker to be announced in Final Program. (1.5 hrs.)

9 AM/Parlor A
AMERICAN ACADEMY OF PEDIATRICS,
MARYLAND CHAPTER

Pediatric Residents' Papers

Other topic and speaker to be announced in Final Program. (1.5 hrs.)

9 AM/Parlors C and D
AMERICAN COLLEGE OF EMERGENCY
PHYSICIANS, MARYLAND CHAPTER

Topic and Speaker to be announced in Final Program. (1.5 hrs.)

9 AM/HUNT ROOM
DEPARTMENT OF FAMILY MEDICINE,
UNIVERSITY OF MARYLAND SCHOOL
OF MEDICINE

The Medical Record, An Absolute in Medical Care

This program will be presented by members of the Department of Family Medicine, University of Maryland School of Medicine, under leadership of **Edward J. Kowalewski, MD.** Additionally, final arrangements are in progress for a most-qualified out-of-state speaker. (1.5 hrs.)

10:30 AM/GARDEN ROOM
MARYLAND SOCIETY OF OTOLARYNGOLOGY

Voice Disorders: Evaluation and Management

Moderator: **Haskins Kashima, MD, Baltimore**

Other program participants to be announced in Final Program. (1.5 hrs.)

A scientific exhibit will be an adjunct to the scientific program.

Exhibit: Voice Disorders: Diagnosis of Laryngeal and Systemic Disorders (An audiovisual exhibit). Participating Institutions: Johns Hopkins University School of Medicine and Loyola College.

10:30 AM/Parlors C and D
AMERICAN DIABETES ASSOCIATION,
MARYLAND AFFILIATE, INC.

New Information About Old and New Insulins
John A. Galloway, MD, Indianapolis, IN (1.5 hrs.)

**12:15 PM/INDOOR POOL AREA
MEET THE SPEAKERS**

The program speakers participating in the **FRIDAY MORNING SESSIONS** will be available to meet with attendees on an informal basis over lunch. **TICKETS FOR A SPECIFIC TABLE MUST BE PURCHASED AT THE DOOR TO THE INDOOR POOL AREA BEGINNING AT NOON FRIDAY.** Lunch will then be obtained from the adjacent Paddock Bar Buffet. Ticket: \$4.50 Complimentary coffee available in Pool Area. **SEATING LIMITED TO 10 PERSONS AT EACH TABLE.**

**12:15 PM/VALLEY BALLROOM
(EXHIBIT HALL)
EXHIBITORS' SWEEPSTAKES**

Drawing for Prizes

1st prize — \$500 CASH

2nd prize — \$200 CASH

See additional information in front of this program under **EXHIBITS.**

**2 PM/MARYLAND ROOMS I AND II
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE**

Genetics Program

Participants: Faculty of the Johns Hopkins University School of Medicine.

Specific Topics and Speakers will be announced in the Final Program. (3 hrs.)

**2 PM/MARYLAND ROOM III
MARYLAND SOCIETY OF PATHOLOGISTS**

Malignant Lymphomas as Neoplasms of the Immune System
Elaine S. Jaffe, MD, Bethesda (1.5 hrs.)

**2 PM/MARYLAND ROOM IV
LONG TERM CARE COMMITTEE**

Essentials in Care of the Elderly
William Reichel, MD, Baltimore (1.5 hrs.)

**2 PM/GARDEN ROOM
OBSTETRICAL AND GYNECOLOGICAL
SOCIETY OF MARYLAND**

Reproductive Health: New Issues, New Challenges
Irvin M. Cushner, MD, MPH, Washington, DC (1.5 hrs.)

**2 PM/PARLOR A
PEER REVIEW COMMITTEE, COMMITTEE
ON PHYSICIAN REHABILITATION, AND
COMMISSION ON MEDICAL DISCIPLINE**

SEMINAR ON THE IMPAIRED PHYSICIAN

Open Meeting: International Doctors Anonymous, including recovered physicians from Med-Chi's Committee on Physician Rehabilitation.

Daniel J. Anderson, PhD, Center City, MN (3 hrs.)

**2 PM/PARLORS C AND D
MARYLAND SOCIETY OF NUCLEAR MEDICINE**

Advances in Nuclear Medicine . . . for the Practicing Physician
Gerald S. Freedman, MD, New Haven, CT (1.5 hrs.)

**3:30 PM/MARYLAND ROOM III
MARYLAND STATEWIDE PSRO COUNCIL**

PSRO and Its Effect on Your Practice

John Bussman, MD, Portland, OR
Stanley I. Fishman, MD, FACP, Brooklyn, NY
Emidio A. Bianco, MD, Baltimore
John J. Kent, Jr., JD, MPS, Baltimore (1.5 hrs.)

3:30 PM/MARYLAND ROOM IV

The Pulmonary Manifestations of Collagen-Vascular Diseases
Allen R. Myers, MD, Philadelphia, PA (1.5 hrs.)

**3:30 PM/GARDEN ROOM
MARYLAND SOCIETY OF REHABILITATION
MEDICINE**

Spine-Related Pain Syndromes: Office Diagnosis and Management
Lionel A. Walpin, MD, Beverly Hills, CA (1.5 hrs.)

**7:30 PM/MARYLAND BALLROOM
PRESIDENTIAL RECEPTION AND BANQUET**

Reservations required. Use reservation form at back of this program.

**SATURDAY,
MAY 5**

**9 AM/MARYLAND ROOMS III AND IV
HOUSE OF DELEGATES MEETING**
(New Council meets immediately following adjournment of House of Delegates)

THIS ANNUAL MEETING SCIENTIFIC PROGRAM IS ACCEPTABLE FOR 18 CATEGORY I CREDIT HOURS FOR THE AMA PHYSICIAN'S RECOGNITION AWARD, AND REQUIRED CREDIT HOURS FOR CONTINUING MEDICAL EDUCATION BY THE MARYLAND STATE BOARD OF MEDICAL EXAMINERS. PRESCRIBED HOURS BY THE AMERICAN ACADEMY OF FAMILY PHYSICIANS HAS BEEN APPLIED FOR.

MEAL FUNCTIONS AND SOCIAL ACTIVITIES

Please use Reservation Form at back of this program to register for all meal functions. All functions to be held at Hunt Valley Inn. **TICKETS WILL NOT BE MAILED, BUT WILL BE HELD AT THE ADVANCE REGISTRATION DESK IN THE REAR OF THE EXHIBIT HALL.**

MMPAC LUNCHEON

The Maryland Medical Political Action Committee Luncheon will be held **WED., MAY 2, 12:15-1:45 PM**, in the Hunt Room. Topic and Speaker will be announced in the Final Program.

Everyone is invited. **Preregistration required. Tickets \$7.50 per person.**

HOSPITALITY NIGHT

This complimentary social hour has proved to be a very enjoyable part of the Annual Meeting, and will be held again this year on **WEDNESDAY, MAY 2, 5:30-7 PM**, Hunt Room. Cocktails and hors d'oeuvres will be served and entertainment will be furnished by a strolling instrumental trio. There is no charge, and tickets will not be distributed; however, you must indicate on the reservation form, at back of this program, the number of reservations you wish to make.

PRAYER BREAKFAST

THURSDAY, MAY 3, 7:30-9 AM is the time scheduled for the Prayer Breakfast, to be held in the Hunt Room. The Speaker will be Reverend Clyde Shallenberger, who will speak on the topic "What Hath Man Wrought?"

This session is approved for one hour of Category I CME credit. **Preregistration required—tickets \$6 per person.**

LUNCH AND LEARN SESSION

These popular round table discussions will be held again on **THURS., MAY 3, 12:15-1:45 PM**, in the Hunt Room. A detailed list of topics to be discussed is published elsewhere in the Advance Program. A number of the tables sell out very early. It is necessary to make your reservation promptly to ensure your choice of tables. **Preregistration required. Tickets \$10 per person.**

DINNER AND SQUARE DANCE

A dinner and square dance cosponsored by the Auxiliary will take place on **THURSDAY, MAY 3**, in the Maryland Ballroom.

6:30 PM — NO HOST BAR

7:30 PM — DINNER

8:30 PM — SQUARE DANCE

Preregistration required—tickets \$17 per person. NO HOST BAR.

MEET THE SPEAKER

A new session this year which will give you an opportunity to meet informally with the Speakers from the Friday morning scientific sessions and discuss their topics. This session will be held from 12:15-1:45 PM around the indoor pool, and tickets must be purchased for specific tables. Tickets will go on sale at **NOON** at the door to the indoor pool area. **Seating limited to 10 persons at each table. Tickets \$4.50 per person.**

AUXILIARY LUNCHEON

All Auxiliary members, spouses, and guests are invited. Luncheon and Cash Bar to be held **FRI., MAY 4**, in the Hunt Room.

12:30 PM — CASH BAR

1 PM — LUNCHEON

Preregistration required. Tickets \$7.50 per person.

PRESIDENTIAL RECEPTION AND BANQUET

The Presidential Reception and Banquet honoring Dr. and Mrs. Francis C. Mayle will be held **FRIDAY, MAY 4, 7:30 PM** in the Maryland Ballroom. Dress is optional. A formal invitation is enclosed with this mailing.

All members and their guests are invited. **Preregistration required. Tickets \$26.50 per person.** (For more details turn page.)

Coming in the Journal:

PROPHYLAXIS OF THROMBOEMBOLIC DISEASE,

by Matthew J. Gibney, III, MD

PERITONEAL ADHESIONS: WHERE DO WE STAND?

by Abdallah Alameddine, MD

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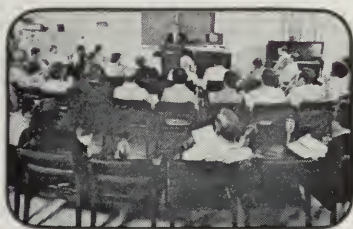
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The Library Page

Cover Story:

Acute Mountain Sickness

By JOSEPH E. JENSEN

Mr. Jensen, Faculty Librarian, can be contacted for reprint and other data c/o the Library, Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral St., Balto., MD 21201.

Acute mountain sickness is a syndrome resulting from maladjustment to high altitude. The condition is unpleasant, characterized by headache, vomiting, shortness of breath at rest, lassitude and ataxia. It is usually self-limiting.¹⁻² However, there are two potentially fatal variations—high altitude pulmonary oedema and cerebral oedema.

Acute mountain sickness was recognized by 19th Century mountaineering physicians, has been discussed in occasional articles in major medical journals throughout the last 100 years and is mentioned in most 20th Century medical textbooks; however, within the last 15 years, the disease has achieved notoriety. Present-day technology and economic conditions now permit individuals to be at sea level in Baltimore one morning and to be skiing above 10,000 feet in Aspen, CO the next. During the summer months 3,600 people a day drive to the 14,000-foot summit of Pike's Peak.³ A recent article in the *Lancet* reported that, during one month in 1975, 648 tourists backpacked for several days along a high, narrow trail to reach the Nepalese village of Pheriche at 14,000 feet.⁴ Their goal was a 17,700-foot point, two days further on, where they could view Mt. Everest. The tourist industry has found an area for expansion by sponsoring such high-altitude treks. Mountaineering clubs, which sponsor treks and expeditions to the high areas of the world, exist in almost every American city, and their membership rolls are teeming. The spiraling increase in the number of flatland tourists who are joining the ranks of hikers, trekkers, skiers and mountaineers seeking adventure at high elevations has raised acute mountain sickness from a curiosity to a major medical concern.

It is possible that half of the individuals who undertake these adventures will succumb to acute mountain sickness.⁴ More than 2% will develop high altitude pulmonary oedema or cerebral oedema, and some of these will die.³⁻⁵ Acute mountain sickness is therefore a concern for all physicians. Physicians themselves represent a goodly portion of the thousands who are heading for the high country, and those accompanying trekking groups in the mountains have often shown themselves to be totally and tragically ignorant of the ailment and its consequences.⁴ The less adventurous physicians who never leave the flat land will find their patients inquiring about preventing and/or treating acute mountain sickness.

The mildest form of the disease is a combination of trivial symptoms—headache, dizziness, nausea, loss of appetite, sleeplessness or giddiness. The headache can usually be controlled with aspirin or codeine, and the condition is usually gone in four to eight days.^{1-2,4}

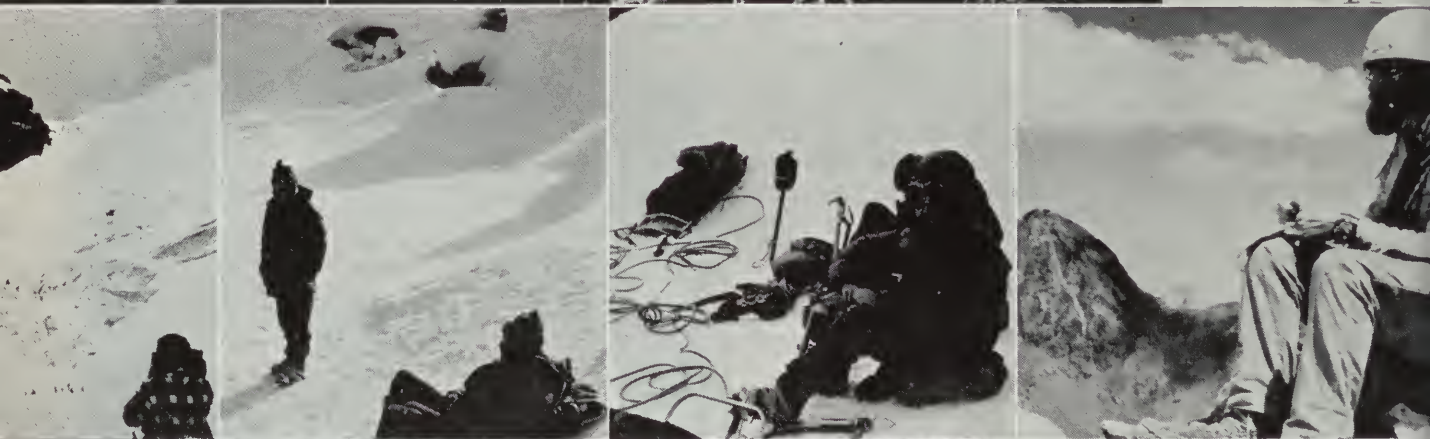
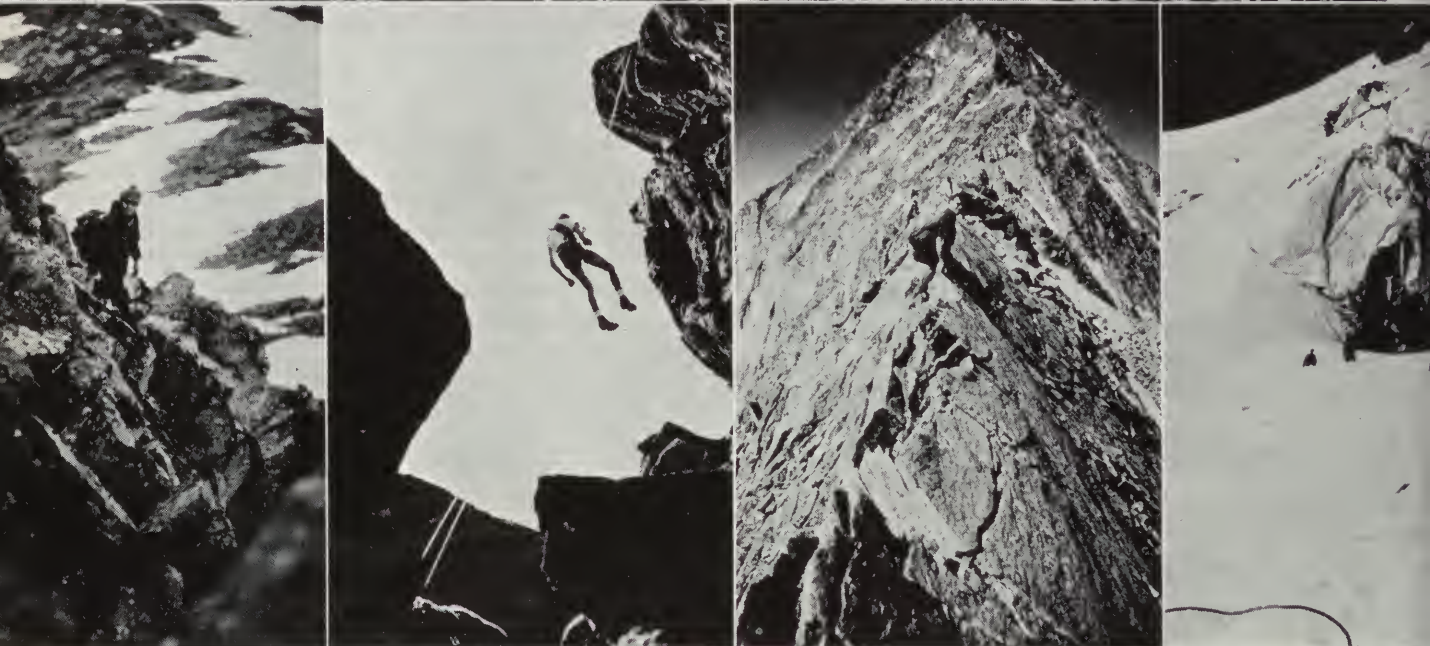
More serious symptoms include headache not relieved by aspirin or codeine, vomiting, chest discomfort with shortness of breath, malaise and lassitude, ataxia, tachycardia and oliguria.^{1,3-4}

In its severe and potentially fatal forms, acute mountain sickness develops into pulmonary oedema or cerebral oedema. Pulmonary oedema is indicated by rapid onset tachypnoea, hypotension, cyanosis at rest, rales, tachycardia and mild fever.³⁻⁴ Cerebral oedema is characterized by incapacitating headache, gross ataxia, disorientation and hallucinations, paralysis and usually by papilloedema and coma.⁴ Recovery from both severe forms of acute mountain sickness is rapid upon descent to lower elevations.³

Acute mountain sickness can occur in any healthy individual who rapidly travels from a low area to an elevation above 9,000 feet.⁶ The disease cannot be predicted.³ It does not appear to be related to the victim's physical condition, sex, previous altitude experience or to the load being carried.⁴ It can be closely correlated to speed of ascent and overexertion.⁴ In general, the higher, faster and harder one ascends, the more likely he is to develop acute mountain sickness.³ Incidence increases in the young.⁴ Severity is inversely related to age and to the highest altitude previously attained.⁴



THE AUTHOR AND COVER PHOTOGRAPHER, JOSEPH JENSEN signing the register on Little Bear Peak (14,037 ft.) in Southern Colorado. Mt. Blanca (14,317 ft.) is in the background. Over the last decade, Mr. Jensen has climbed 107 peaks over 14,000 ft. high. (Photography by Leonard Ellis.)



The mechanisms behind acute mountain sickness remain obscure. Hypoxia is almost certainly the beginning phase. Antidiuresis usually occurs prior to the onset of other symptoms.²

The best summary of current understanding of the condition appeared in a recent editorial in *Lancet*.³ Acute mountain sickness could be the result of brain cell compression. Sometimes an increase in cerebrospinal pressure accompanies it. In cerebral oedema, increased membrane permeability caused by hypoxia brings on severe oedema, increasing intercranial pressure, which shuts off the blood flow. High-altitude pulmonary oedema may be a form of neurogenic pulmonary oedema. A massive, central, sympathetic discharge shifts blood from the systemic to the pulmonary circulation, causing pulmonary hypertension, lung hemorrhage, increased capillary permeability, malperfusion and maldistribution of ventilation.

Treatment of the commoner, less severe forms of acute mountain sickness consists of aspirin or codeine for headache, sleeping pills for insomnia and slowing the rate of ascent. Stopping the trek for a day or more to acclimatize is usually helpful. The majority of those afflicted with the sickness will be able to continue later.⁴ It is essential, however, to keep in mind that the severe and potentially fatal forms of this disease progress rapidly and with very little warning. High-altitude pulmonary oedema and cerebral oedema can arise in and kill a person within a matter of hours.⁴ Immediate descent is the only effective treatment and is called for with anyone who experiences severe, constant and uncontrollable headache, uncharacteristic weakness or fatigue or who develops a dry cough, cyanosis or rales or becomes ataxic or confused.³⁻⁵

If oxygen is available, it should be administered. Morphine may help divert blood back to the systemic circulation.³ Frusemide may be helpful in treating established pulmonary oedema,² although its effectiveness has not been proven in controlled studies.³ Betamethasone has been used to treat cerebral oedema;² however, delaying descent to send for help, oxygen or drugs is usually futile; in no circumstance should descent be delayed.

The more severe forms of acute mountain sickness are especially deceptive. The confusion that is symptomatic of pulmonary oedema or cerebral oedema will often prevent the victim from being aware of the onset of serious complications, and he will insist that he is well and capable of proceeding. It is therefore essential that all individuals going to high altitudes be familiar with the dangers and symptoms of acute mountain sickness and its complications so as to watch for their development in their companions. Fatalities result from not diagnosing symptoms early enough and not forcing ailing individuals to descend.³ If descent is begun early enough, most victims recover after descending 3,000 feet, or at least to 10,000 feet.¹

Chemical prophylaxis of acute mountain sickness is a topic of much debate in the correspondence columns of several journals. Accounts are generally anecdotal, and to date there has been no controlled study that demonstrates the effectiveness of a drug in preventing this sickness.

The two drugs currently debated are acetazolamide and spironolactone. Acetazolamide causes a slight diuresis and relative metabolic acidosis. It is also thought to temporarily reduce cerebrospinal fluid production in some people.³ In 1975, Hackett, Renee and Lavine⁴ studied the effect of acetazolamide in preventing acute mountain sickness in 278 individuals trekking to the Mt. Everest base camp in Nepal. Those persons who volunteered to take part in the study used either acetazolamide or a placebo, administered in a double-blind fashion. Those who did not volunteer were used as controls. The authors concluded from this study that acetazolamide ameliorates acute mountain sickness and is a useful prophylactic, especially in individuals who fly directly to high elevations.

The validity of this conclusion has been challenged because of the statistical methods used.⁹ It is also suggested that administration of acetazolamide could be detrimental by causing potassium depletion. The combination of physical exercise and potassium depletion in an individual may cause acute rhabdomyolysis and lead to renal failure. Without determining why, the study by Hackett and his companions does suggest that

1	2	3	4	5
6	7	8	9	
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14	15	16		

READING LEFT TO RIGHT -
TOP TO BOTTOM

1. Leonard Ellis on South Maroon Peak (14,156 feet), near Aspen, CO. (Photo. by Joseph Jensen.)
2. Gil Thorpe on "The Roof," Castle Rock, Boulder Canyon, CO. (Photo. by Jensen.)
3. The author on a wall in the Grand Teton National Park in Wyoming. (Anne Phemister, photographer.)
4. Robert Ryan on a wall along the Potomac River, Great Falls, VA.
- 5 and 6. The author on El Diente (14,159 feet) in southern CO. (Leonard Ellis, photographer.)
7. Rappelling off the summit of the Third Flat Iron, Boulder, CO. (Jensen.)
8. The author on Pyramid Peak (14,018), near Aspen. (Ellis, photographer.)
- 9 and 10. Descending Mt. Rainer, WA. (Jensen.)
- 11 and 12. The author inside the summit crater on Mt. Rainer (14,410 feet), near Seattle, WA.
13. The author on summit of Little Bear Peak (14,037 feet), CO. (Ellis.)
14. Descending Mt. Rainer, WA. (Jensen.)
15. The author on Pyramid Peak, CO. (Ellis.)
16. The author watching sunrise over Wilson Peak, CO. (Ellis.)

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administration of acetazolamide under certain conditions may do more harm than good.

The other drug currently in vogue as prophylaxis for acute mountain sickness is spironolactone. The evidence for the effectiveness of this drug is so far entirely anecdotal. The first report¹ of its possible effectiveness was based upon a self-experiment conducted by Currie and 10 companions (seven of whom were physicians) in two trips to Nepal. The dosage was 25 mg., three times a day, for two days preceding and during periods spent at elevations above 10,000 feet. The theoretical basis for the use of spironolactone is that it counteracts the positive aldosterone response to adaptive plasma volume depletion at altitude. Spironolactone does not cause potassium depletion, as does acetazolamide.⁷ Among Currie and his companions, no acute mountain sickness occurred in those individuals taking spironolactone.

McFarlane⁸ attacked Currie's use of spironolactone as theoretically unsound and suggests that its use may be antitherapeutic. He cites a study showing that those who suffer the most severe symptoms of acute mountain sickness show the greatest decrease in aldosterone excretion, and, accordingly, the administration of spironolactone may accentuate this phenomenon. A later article by Currie⁹ refutes McFarlane's contentions, mainly by citing other studies of aldosterone excretion in acute mountain sickness that reflect contradictory results.

Two additional accounts of successful use of spironolactone to prevent acute mountain sickness have since appeared in the literature. Both are anecdotal and involve small groups. Fifteen individuals on a trip to the Mt. Everest base camp from Dec. 13, 1976-Jan. 16, 1977, began taking the drug eight hours before their flight to the starting point. All successfully reached the base camp at 18,000 feet. Of the 15, only three could have been regarded as showing evidence of even slight acute mountain sickness.¹⁰

Another report involved 12 non-acclimatized Europeans climbing 19,000-foot Kilimanjaro in Tanzania in 1976. These attempted a double-blind trial of spironolactone. All members took either 25 mg. of spironolactone or a placebo tablet three times a day for 48 hours before reaching 10,000 feet. Of the six on spironolactone, two developed acute mountain sickness, while five of the six on the placebo developed the disease.¹¹

The question of chemical prophylaxis for acute mountain sickness obviously remains open. Each report ends with a statement that the small number of subjects, or the reporting or investigating methods, made the results inconclusive, and each report calls for a controlled clinical trial of the effectiveness of both drugs.

Almost all studies and reports, however, confirm the prophylactic measures long known and used by experienced mountaineers and guides. These essentially require time adaptation to altitude.^{1,4,9,12} The technique is easily described—ascend slowly. Climb high, but spend nights down low to acclimatize.³⁻⁴ Above 7,000 feet it is best to limit the rate of ascent to 1,500 feet per day. Above 10,000 feet, the rate should be slowed to 1,000 feet per day.^{4,9}

Hackett's study⁴ effectively demonstrates the value of these measures. The 52% of his subjects who developed the sickness were those who ascended most rapidly and spent the fewest days in reaching their goals. This study also confirmed that slow ascent reduces both the incidence and severity of acute mountain sickness, high altitude pulmonary oedema and cerebral oedema, but to do *anything* slowly and leisurely is not consistent with our times. More and more individuals will fly to high elevations such as Lukla at 9,000 feet to begin a trek to a higher goal, like the base camp of Everest. Tourist agencies and outfitters will promote short trips like this, despite evidence that longer, slower approaches from lower elevations confer substantial protection from acute mountain sickness.

Two British physicians in the successful British Everest expedition in 1975 were alarmed upon their descent from the mountain to find 100 trekkers planning to do the last stages of the approach to the base camp in less than half the time the expedition team had taken earlier.¹²

As technology and economic well-being continue to improve access to higher elevations of the world, increasing numbers of individuals will climb too high and too fast, and the consequences will provide statistics for medical journal articles.

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(For a more complete bibliography of articles on acute mountain sickness published since 1966, contact the Faculty Library.) ☐

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 .M 121v **Victims No More.** Center City, MN, Hazelden, 1978.
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- WE 141 **Musculoskeletal Disorders: Regional Examination and Differential Diagnoses.** Phila., PA, Lippincott, 1977.
 .M 985 1977

Brain

- WL 358 Segal, Gail
 .S 454p **A Primer of Brain Tumors.** Chicago, Association for Brain Tumor Research, 1978.
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 W 820 Walker, Arthur Earl
 .W 177c **Cerebral Death.** Dallas, Professional Information Library, 1977.
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Cardiology

- WG 140 Abildskov, J.A.
 .A 148o **Optimal Electrocardiography.** Hyattsville, MD, Natl. Ctr. for Health Service Research, 1977.
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 WG 17 Salcedo, Ernesto E.
 .S 162a **Atlas of Echocardiography.** Phila., PA, Saunders, 1978.
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Diabetes Mellitus

- WK 835 Diabetes and the Heart. Springfield, IL, Thomas, 1978.
 .D 534 1978

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- WE 800 Abramson, David S.
 .A 161c **Circulatory Diseases of the Limbs: a Primer.** New York, Grune and Stratton, 1978.
 1978

Family Practice

- WB 100 **Family Practice.** Edited by Robert E. Rakel and Howard Conn. 2nd ed. Phila., PA, Saunders, 1978.
 .F 198 1978

Group Practice

- W 92 American Medical Association. Dept. of Practice Management
 .A 512g **Group Practice Kit.** Chicago, IL, 1977.
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Hypertension

- QV 150 McMahon, F. Gilbert
Management of Essential Hypertension. Mount Kisco,

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- WM 171 **Mood Disorders.** Edited by Frank J. Ayd and Irving J. Taylor. Baltimore, Ayd Med. Communications, 1978.
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Mental Health Services

- WM 30.3 Greenblatt, Milton
 .G 789p **Psychopolitics.** New York, Grune and Stratton, 1978.
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- WB 940 Jones, Bob E.
 .J 76d **The Difference a DO Makes.** Oklahoma City, Ok., Times Journal Pub. Co., 1978.
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Prisons

- HV 8833 AMA
 .A 512p **Practical Guide to the AMA Standards for the Accreditation of Medical Care and Health Services in Jails.** Chicago, IL, 1978.
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Radiography—in Infancy and Childhood

- WN 240 Oestreich, Alan Emil
 .O 29p **Pediatric Radiology.** Flushing, NY, Med. Examination Pub. Co., 1977.
 1977

Skin Neoplasms

- WR 17 Kopf, Alfred W.
 .K 83a **Atlas of Tumors of the Skin.** Phila., PA, Saunders, 1978.
 1978

Tumor Virus Infections

- QZ 200 Aubertin, J.
 .A 889o **Opportunistic Infections in Cancer Patients.** New York, Masson Pub., 1978.
 1978

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to members of Med-Chi during the month of December, 1978:

1. Hyperbilirubinemia and phototherapy 51 citations
2. Testicular neoplasms. Updates
 on treatment 32 citations
3. Adult intussusception 52 citations
4. Relationship of liver function to infections
 in the pediatric age group 24 citations
5. Use of Lithium while breastfeeding 8 citations
6. Fluorouracil treatment of warts 15 citations
7. Association between pulmonary emboli and
 pericarditis 3 citations
8. Postoperative intestinal decompression 11 citations
9. Postpartum depression 12 citations
10. Methylphenidates in Schizophrenia 10 citations

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WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purlinethol[®] (mercaptapurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptapurine or azathioprine. Subsequent adjustment of doses of Purlinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

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PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

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Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

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Doctors in the News

Artwork Awarded

Sue Seif, a student in the Johns Hopkins School of Medicine's Department of Art as Applied to Medicine, and Dr. A. Lee Dellon, Resident in Plastic Surgery at Hopkins Hospital, have been awarded first prize by the American Cleft Palate Educational Foundation for their essay on auditory tube function.

The cash awards and plaques were awarded at the Third International Cleft Palate Congress in Toronto recently.

Based on Ms. Seif's research for her Master's Degree in medical and biological illustration, the essay describes the anatomy and relationships of the auditory tube and surrounding structures. A model for auditory tube function is presented which answers several previously-debated questions of

clinical significance in cleft palate repair.

Ms. Seif, a native of Baltimore, is a graduate of Goucher College and was Assistant to the Director of Public Relations at Johns Hopkins for several years before entering graduate school. A Teaching Assistant in Gross Anatomy at the medical school, she received her Master's Degree.

Dr. Dellon earned both his Bachelor's and Medical Degrees at Hopkins. He is Chief Resident in Plastic Surgery at Hopkins. □

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride, International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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For prescribing information see opposite page.



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However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).



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J-6857-4

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Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

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NDC 0009-0733-02

Motrin Tablets, 400 mg (orange)

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Routine Screening for Hemoglobinopathy in Blacks

By JOSEPH M. MILLER, MD and DEBORAH C. DAVIS, BS

Dr. Miller and Ms. Davis can be contacted for reprint and other data at Provident Hosp., Inc., 2600 Liberty Heights Ave., Balto., MD 21215, where Dr. Miller is Director of Continuing Medical Education.

The hemoglobinopathies constitute a major health problem in blacks who comprise a sizable portion of the Baltimore population. Screening by hemoglobin electrophoresis and solubility tests have demonstrated an incidence of 10.98% in 64,711 individuals investigated.

Percentages obtained from the Sick Cell Screening Clinic and inpatient screening were the same. Some cross-over surely occurred in this investigation, as the Hospital is situated in an area serving 204,734 blacks in 39 census tracts (1970). In the Screening Clinic, the percentage of hemoglobinopathy was 10.97 (4,336/39,510), while inpatients showed a percentage of 10.98 (2,770/25,201). These numbers testify to the natural observation that the Hospital derives its clientele from the surrounding area.

The sickle cell trait frequency in the Screening Clinic was 7.85%, while the group in the hospital comprised 7.86%. Sickle Cell trait is thus not found in Hospital patients to a greater degree than exists in individuals in the community, and apparently is not associated with some forms of morbidity which would make it more likely for that individual to show up in a hospital population.

The 10.97% rate does suggest, however, that if one out of every 10 black individuals admitted to a hospital for some reason has a hemoglobinopathy, then a hem-

oglobin screening should be done on all such patients. The risk of missing a hemoglobin variant which may influence the clinical course of the patient is more than the physician should be willing to assume.

The clinical objection that individuals with sickle cell trait usually have a benign and unimpaired life-span may not be entirely true. Hyposthenuria, hematuria and renal infarction are fairly well-documented in this hemoglobinopathy. Splenic and pulmonary infarction may occur under conditions of low oxygen tension or in shock. Pyelonephritis and urinary tract infection are other complications. Because of the risk of hypoxia during surgery, the presence of the trait should be known to the operating team.

The best procedure to discover the hemoglobinopathies is to do a hemoglobin electrophoresis. A solubility test with sodium dithionite is performed in those patients with hemoglobin migrating in the sickle cell band. If a hemoglobin C were demonstrated, a citrate agar electrophoresis was done to determine whether or not hemoglobins C, E or O were present. Further delineation of the C band was accomplished by a solubility test to differentiate between hemoglobins C and C Harlem.

The routine practice of medicine and surgery involving black patients should include a hemoglobin screening when the patient enters the hospital. Because the test can be easily done, it should be included among initial laboratory procedures. Information yielded to the physician under certain circumstances may be helpful in arriving at a diagnosis. ☐

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The Physician's Role in Narcotic Abuse

By KENNARD L. YAFFE, MD
Chairman, Med-Chi Committee on Drugs

Following is a report of one day's hearings of the House Select Committee on Narcotics Abuse and Control, as published by the Pharmaceutical Manufacturers Association in its *Newsletter* of Sept. 25, 1978:

If the House Select Committee on Narcotics Abuse and Control thought that last Wednesday's witnesses—a journalist, a pharmacologist, a psychiatrist and an AMA trustee—could enlighten the Congress about "overprescribing" physicians, four hours of testimony proved otherwise.

"I will begin by stating my bias, and that is I believe we live in an overmedicated society," journalist John Pekkanen (author of *The American Connection*) began. "My area of special concern has long been legitimately-prescribed psychoactive drugs." The rest of his testimony and answers did not live up to the Committee's expectations. True, he said that the drug companies "court" the doctors, but, he continued, "The problem is extremely complex. Everybody I talked to is very concerned . . . It's very difficult to determine precisely who needs psychoactive drugs . . . The symptoms are vague;" and, he stressed, "Never underestimate patient demands."

Next came Dr. T. Donald Rucker, Chairman of the Ohio State University Pharmacology Department, who bemoaned the lack of an adequate data base in 23 pages of testimony and tables.

The two American Medical Association witnesses, Daniel X. Freedman, University of Chicago Psychiatry Department Chairman and Joseph Boyle, Los Angeles internist and AMA trustee, warned about the complexity of easy accusations. "We do not believe that statistics regarding the total annual number of prescriptions written for a particular drug can really answer questions pertinent to whether there is overprescribing or misprescribing of that drug," Dr. Boyle said. "Higher than expected use of these drugs could also be attributed to increased access to health care now available under Federal programs such as Medicare and Medicaid or to the trend in treating mental illness in the community rather than in institutions. A greater willingness among some groups to seek help can lead to increased uses of these drugs in certain populations. In any event, it must be remembered that conditions such as anxiety are often attributable to factors beyond the control of medicine, such as inflation, unemployment, family relationships and shifting social values."

They explained what the AMA has done to assure wise prescribing:

- The AMA's Drug Evaluations, published in cooperation with the American Society of Clinical Pharmacology and Therapeutics, Dr. Boyle said, "is designed to provide practicing physicians with an up-to-date, unbiased, scientific evaluation of available drugs." The section on psychotropic substances warns the physician to guard against "contributing to drug abuse through injudicious prescription practices or by acquiescence to the demands of some patients for instant chemical answers to their problems."

- "When it can be established that a physician or other prescriber is prescribing or dispensing drugs for non-medical use, appropriate actions should be taken to halt such activity. We support strict enforcement of the law."

- "The AMA has been especially active in working to improve medical discipline at the state level. We have developed model state legislation on the subject of physician discipline."

- "The AMA supports efforts designed to eliminate improper prescribing, and we believe the principal means for achieving such a result is to provide unbiased, valid and current information to physicians on the risks and benefits of particular drugs in various treatment situations."

- "The AMA Archives of General Psychiatry over the past decade has published major controlled studies relating to the efficacy and side effects of psychotropic drugs. In addition, major

national surveys of prescription drug use have also been published in order to more reliably inform physicians concerning drug use."

That's not enough, the Committee indicated.

Paul Rogers (D, FL): "What's the AMA doing for leadership?"

Boyle: "We have a committee on substance abuse to advise the states."

Rogers: "Don't you think you should establish a staff to investigate?"

Boyle: "Our function is to advise. We have no authority, we're not a regulatory agency; we can't go into the physician's office."

Lester Wolff (D, NY): "Are there no AMA standards?"

"You have not assumed real leadership," Rogers told the AMA witnesses. "I want a letter from the AMA, telling us what it can and will do in regard to improper overprescribing."

The Faculty's Committee on Drugs faces this kind of problem continuously, and so asked our Executive Director to let the House Select Committee on Narcotics Abuse and Control know that Maryland is not sitting back, waiting for someone else to solve this problem. John Sargeant wrote the following letter:

"The Hon. Lester L. Wolff, Chairman
House Select Committee on Narcotics Abuse and Control
Rayburn House Office Building
Wash., DC 20515

Dear Mr. Wolff:

We have read a "thumb-nail" report of the testimony before your committee by witnesses from the AMA, among others, concerning overprescribing physicians. We are distressed that this article leaves one with the impression that the medical profession doesn't care very much about the problem of over- or mis-prescribing by physicians. Exactly the contrary is true. We believe the problem to be that the wrong people were on the carpet! While it is true the AMA cannot go into physicians's offices, the county and state medical societies can—and we do.

While we cannot speak for other states, of course, we believe that Maryland is fairly typical of other state societies in attempting to keep a handle on the prescribing practices of physicians and to take appropriate action when there is evidence of deviation from the accepted norms of practice. Maryland is one of a handful of states that has promulgated regulations restricting the prescribing of amphetamines. These regulations are presently being revised by the State Department of Health and Mental Hygiene with the advice and cooperation of the Medical and Chirurgical Faculty. Cooperation with the Department and the Faculty continues through pharmacy surveys being forwarded to the medical society for review. The physician is contacted if he is prescribing amphetamines and asked for an explanation of diagnosis, backed up by documentation for such prescribing. Prescribing of other classified drugs is also monitored and those physicians who cannot reasonably explain the use of such drugs are often referred for peer review of their entire practice. The next step, if the practice is found to be sub-normal, is referral to the Commission on Medical Discipline, a state agency.

We don't have all the answers, and perhaps there are a few physicians who slip by without being recognized as poor prescribers, but we believe this whole process to be educational in nature for physicians, and as protective of the public. We, too, support strict enforcement of the law, and cooperate with law enforcement authorities in identifying physicians who abuse the law.

We would be very happy to visit with your Committee, to describe our procedures in more detail and to answer any questions you might have. We have many physicians in Maryland who

freely give of their time and expertise to the problem of improper prescribing, and we are sure this is true in other states as well."

Now read the response from the Chief Counsel of the Select Committee. While his response was possibly not as enthusiastic as we would have liked about the efforts Maryland and some other states are making, we have been able to get on record as a state taking the initiative in acting responsibly to alleviate a perceived problem.

"Your letter to Chairman Wolff of Oct. 3 has been referred to me for reply.

The Select Committee on Narcotics Abuse and Control appreciates your expression of concern. We realize that there are many segments of the medical profession who are concerned and do monitor physician prescribing practices. Your restriction on the prescribing of amphetamines is a major step towards controlling their indiscriminate use. Estimates by the National Institute on Drug Abuse indicate, however, that 600 kilos of amphetamines, 60 million 10-milligram dosage units, are dispensed directly to the patient by the physician as part of the office visit without benefit of a prescription being filled in a drugstore. This 600 kilos represents 20-25% of the total amphetamines dispensed in the United States. The fact that Maryland may carefully regulate amphetamines while other states do not is just one example of the need to establish some basic uniformity between states with respect to dispensing scheduled drugs.

We are taking the liberty of including your letter in our hearing record and look forward to receiving a copy of the final regulations governing amphetamines after they are revised.

Once again, thank you for your interest and cooperation.

Sincerely,

Joseph L. Nellis
Chief Counsel"

This exchange of information might give some indication to members of Med-Chi of the extent of the abuse of amphetamines and the involvement of Maryland's doctors in an attempt to help control the abuse. ☐

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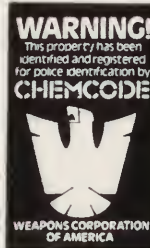
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Validity of the Zung Depression Scale (SDS) in Medical Outpatients

By DAVID RAFT, MD; ROBERT F. SPENCER, MD; TIMOTHY TOOMEY, PhD
and DONNA BROGAN, PhD

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Abstract

Sixty-nine randomly-selected medical outpatients were clinically evaluated for depressive disease. A Zung Self-Rating Depression Scale (SDS) was also administered to each patient. The prevalence of depression in the sample was 42%. While detecting 30% of those depressed, the SDS missed those whose depressive disease was presented under the guise of somatic illness. The SDS is thus a suitable instrument only in screening of the non-depressed medical patients.

Introduction

The prevalence of depression in general medical patients is verified in several studies,¹⁻⁴ yet detection of the depressed patient has remained a major problem of delivery of care. A brief, simpler self-administered questionnaire to identify the patients who suffer from depression has proven to be of considerable value. One such scale is the SDS. We examined its validity against clinical assessment of depression in a population of medical outpatients.

Description of the SDS

The scale is described elsewhere in detail.⁵⁻⁸ It consists of 20 items clinically judged to be discriminative of depression, i.e., lowering of mood, hopelessness, helplessness and biological concomitants of depression such as insomnia and lowered libido. The items are scored from 1-4, yielding a total score ranging from 20-80. This score is converted to a base of 100. Zung⁶ found that those scoring over 70 were generally depressed enough to require hospitalization.

Method

Roughly every fifth patient who presented to the Medical Screening Clinic of NCMH was selected. These patients came complaining of a variety of physical ailments. The population resembled one found in the general practitioner's office. Sixty-nine subjects were asked to complete the SDS. Each patient was then interviewed by one of the authors using a semistructured anamnestic method.

Clinical Classification of Patients

Depression was defined as a syndrome characterized by real or symbolic loss of object with hopelessness and helplessness, low mood or affect, vegetative signs (anorexia, insomnia, decreased libido) and loss of gratification and withdrawal from object relations. All tended to persist more than a month. Of the 29 patients diagnosed as suffering primary depression, 17 denied depression and claimed their sadness was due to physical symptoms. This "masked depression" subgroup showed many physiologic concomitants of depression, and medical investigation failed to uncover organic bases for their complaints.

Patients exhibiting overt thought disorder and excessive rigidity of defenses with extensive projection and denial were classified in the psychotic-borderline category even though they were depressed.

Results

Characteristics of the patients, distribution of the SDS scores and the demographic data are reported elsewhere.⁹ Patients were classified into five diagnostic categories—depression, borderline psychotic, conversion reaction, organic and normal—following psychiatric interview. Table I indicates characteristics for each of the diagnostic samples.

Table 1: Sample Characteristics Across Diagnostic Categories

Diagnosis(N)	Normal (16)	Depressed (29)	Conversion Reaction (10)	Psychosis-Border line (6)	Organic (8)
Mean Age	36.38	38.64	28.40	27.50	67.87
Age Range	18-52	17-64	17-49	21-40	50-85
Mean SDS Index	0.39	0.59	0.49	0.59	0.58
SDS Index Range	0.26-0.54	0.29-0.84	0.35-0.65	0.40-0.76	0.43-0.71
Standard Deviation	9.20/ /±4.60	9.77/ /±2.61	13.04/ /±4.12	16.17/ /±6.60	9.97/ /±3.53

Stepwise Discriminating Analysis

Tables 2 and 3 indicate characteristics which discriminate across diagnostic categories and between masked depression and depression. Considering all diagnostic categories, only three items in the Zung scale are of discriminative value, i.e., suicide, irritability and constipation. When the cases of masked depression are compared with the depressed cases, a single Zung item—sadness—is sufficient to classify 83% of the cases with no increase in discriminative power noted with the addition of other items.

Nine symptom categories (Table 4) were selected for comparison. Severity of symptoms as described by Beck¹⁰ was related clinically from 1-4 in a manner corresponding to the Zung rating. The mean response of the clinical rating was then compared to the mean response on the Zung scale (Figures 1 and 3). Figures 2 and 4 show comparative ratings of depression and

conversion reaction.

Discussion

Consideration of the clinical material presented indicates that the Zung scale does not differentiate between primary depression as defined here (and according to criteria set by Feighner, et al¹¹) and secondary depression, i.e., depression as a manifestation of a variety of physical and psychiatric illnesses. Nor does it separate depression from conversion reaction (Figure 4). While generally reliable, the Zung scale is not a good indicator of masked depression where the patient denies being depressed, although scrutiny reveals that depression underlies his/her various symptoms. This entity was discussed by Kennedy¹² and Bradley¹³ in the 1940s and more recently by Leese,¹⁴ Gallemore⁴ and Cohen.¹⁵

While correlation of clinical evaluation with the Zung SDS is good on overtly depressed patients (Figure 2), the differentiation of a patient suffering masked depression from one with conversion reaction can be determined only after a clinical interview (Figures 1

Table 2: Discriminant Analysis: All Diagnostic Categories

Step #		% Correctly Classified	df	F
1	Age	36%	(4, 64)	13.86**
2	SDS Index	49%	(4, 63)	9.94**
3	Zung item 19 (Suicide)	57%	(6, 62)	7.90**
4	Zung item 15 (Irritability)	59%	(7, 61)	6.74**
5	Zung item 8 (Constipation)	64%	(8, 60)	5.96**

**P < .01

Table 3: Discriminant Analysis: Masked Depression Vs. Depression

Step #		% Correctly Classified	df	F
1	Zung item 1 (Sadness)	83%	(1, 27)	18.22**
2	Zung item 3 (Crying Spells)	83%	(2, 26)	11.81**
3	Zung item 2 (Diurnal Mood)	79%	(3, 25)	8.61**
4	Zung item 6 (Sex)	83%	(4, 23)	7.22**
5	Zung item 13 (Agitation)	83%	(5, 23)	6.17**

**P < .01

CORRELATION OF CLINICAL AND ZUNG ITEMS

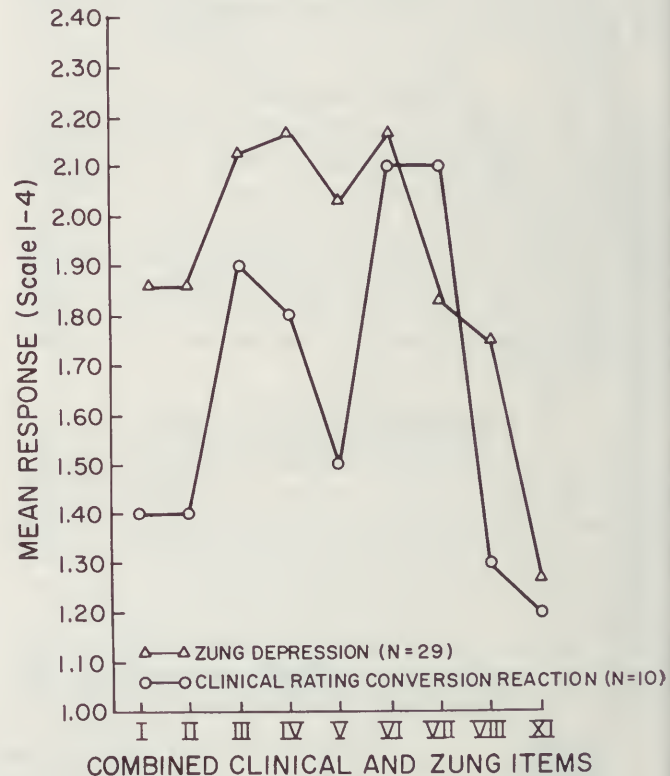
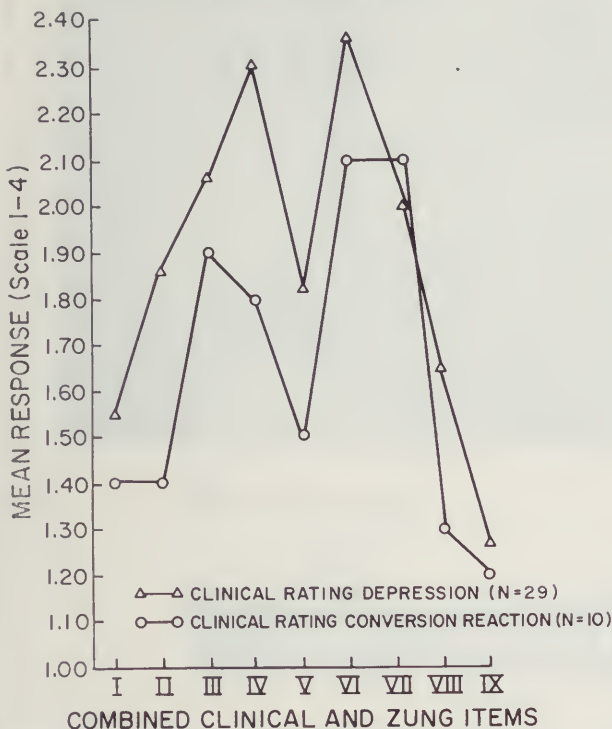


FIGURE 1

Table 4:

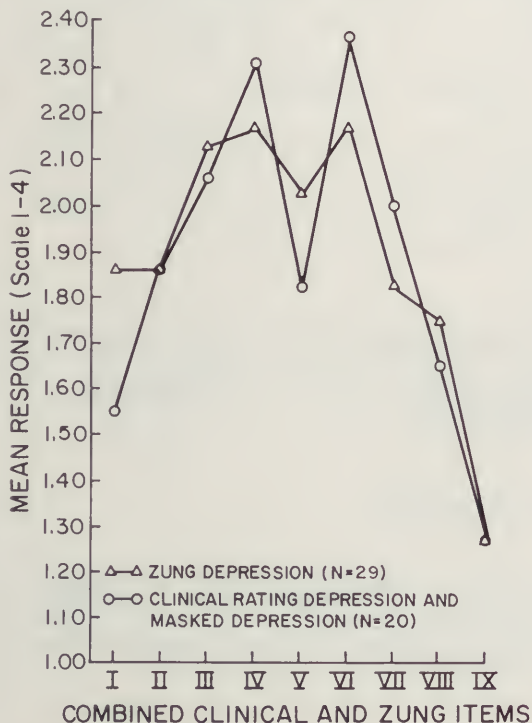
	I	II	III	IV	V	VI	VII	VIII	IX
Clinical Item	Mood/Affect	Appetite and Weight Loss	Insomnia Early and Late	Energy	Agitation	Sex and Interest	Guilt Anger Self-depreciate	Concentration	Suicide
Zung Item 0	1	5 and 7	4	10	13	6	15 and 17	11	19

FIGURE 2
CORRELATION OF CLINICAL
AND ZUNG ITEMS



and 2). Atypical or covert signs of depression manifesting in physical complaints may be an earlier indication of depression;¹⁶ however, Hegg reports that only half the depressed patients (N = 400) complained of low mood.¹⁷

FIGURE 3
CORRELATION OF CLINICAL
AND ZUNG ITEMS



A more sensitive scale than the Zung SDS seems necessary for patients whose primary complaints are somatic and who consult a general medical clinic rather than a psychiatric one.

COMPARISON OF MASKED DEPRESSION
AND CONVERSION REACTIONS

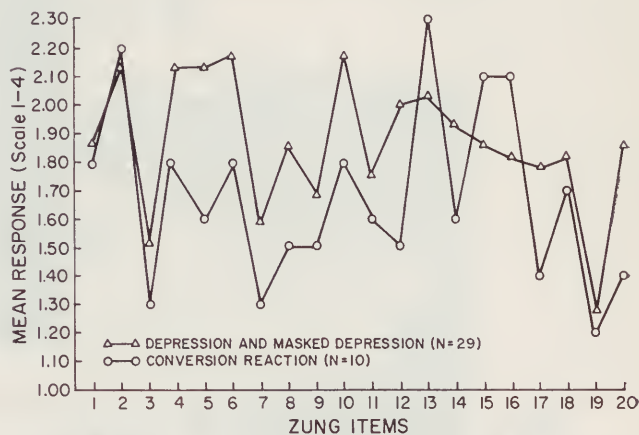
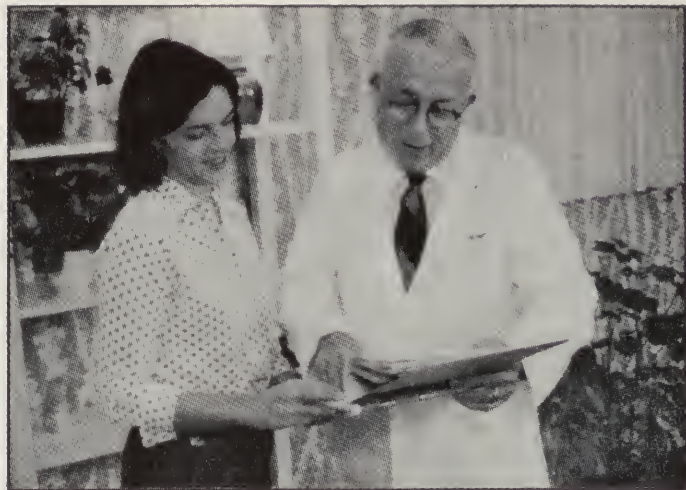


FIGURE 4

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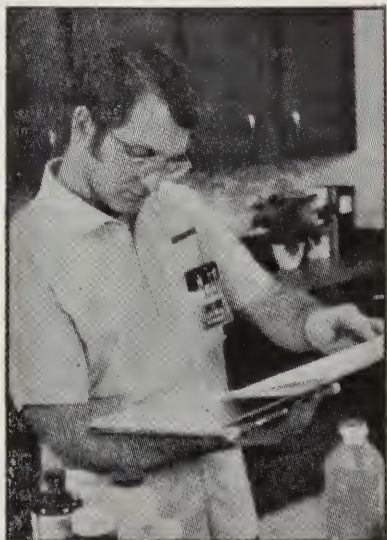


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Nursing Bottle Syndrome

By SOL B. LOVE, DDS

For reprints and other data, write Dr. Love at 204 North Liberty St., Baltimore, MD 21201.

Summary

Nursing bottle syndrome or bottle caries is a form of rampant dental disease affecting the teeth of very young children who are allowed to fall asleep with a nursing bottle or breast in their mouths. The resultant tooth decay can affect the child's health status as well as result in premature loss of the deciduous teeth with results that can last a lifetime.

The physician is in an excellent position to educate the expectant and the new mothers in order to effectively prevent this potentially-destructive condition.

Background

Dental caries remains the most common oral pathology of the very young child. Pain, infection, speech difficulties, developmental and nutritional problems, as well as psychological problems, can be brought on by the rapid tooth decay and loss of primary teeth in nursing children. Commonly-referred to as nursing or baby bottle syndrome and bottle caries, this disease process, which has a definite pattern of distribution, can also occur in children who are breast-fed.

Since very few children are even taken to the dentist prior to age three, it is difficult for dentists to prevent this type of tooth decay. However, the physician has an excellent opportunity to diagnose and even prevent this disease from occurring.

Nursing bottle syndrome is a type of tooth decay seen in very young children who are allowed to fall asleep with a nursing bottle in their mouth. The bottle may contain milk, fruit juice, punch, honey or other carbohydrate containing fluid.

Etiology

The potential destructive effects of carbohydrates, especially the more highly-refined sugars, on teeth has been recognized for many years. Several microorgan-

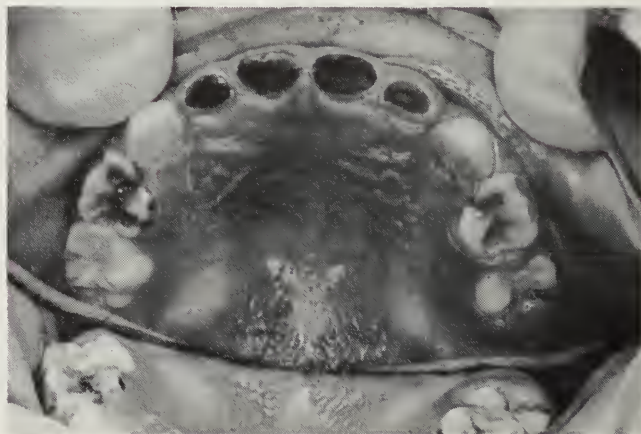
isms normally present in the oral cavity metabolize carbohydrates and produce an acid as a waste product which demineralizes the tooth enamel. Demineralization of enamel is the first step in tooth decay.

When a child is put down for a nap or at bedtime with a nursing bottle in his mouth, the nipple rests against the palate and the tongue is in a forward position covering the lower incisors. As the child falls asleep, the swallowing slows and salivary flow decreases. This creates a pooling of the bottle's contents around all the teeth with the exception of the tongue-protected mandibular incisors. The carbohydrate material in the liquid thus remains in contact with the teeth for a prolonged period of time. All of the factors needed for the carious process to take place are now present, and the resultant effect can be seen in the photographs (see Figures 1 and 2.)

Signs and Symptoms

The decay process generally affects the upper incisors first, then the molars and cuspids (canines) and finally the lower incisors. The carious teeth have areas sometimes involving the entire clinical (visible) crown, and pathologic fracture of teeth is not unusual. The areas of decay may vary in color from light brown or yellow to black. Green stain usually seen only on the labial surface at the gum line is not decay, but a removable stain of remaining parts of the embryonic sac membrane which covers the tooth and is worn away after eruption.

Because many of these affected children are unable to communicate verbally their discomfort, the parent may not become aware of the problem until after serious damage has already occurred. Sometimes the parents notice something wrong after a fall while checking the child for tooth injury. Other parents think the teeth are stained and take the child to the dentist for cleaning. Children who prefer soft foods or who grimace or even cry when chewing cold, sweet or hard foods, should be examined for carious teeth.



FIGURES 1 and 2

Treatment

The method of restoring the teeth varies according to the amount of damage involved. Small cavities can be restored with silver amalgam, plastic or composite (newer version of older anterior tooth-filling material). More severely-damaged teeth will need crowns (caps), usually of stainless steel or polycarbonate (hard plastic). Often a pulpotomy procedure must be carried out. This involves removing as much of the crown portion of the pulpal tissues as possible and packing the pulp chamber with a modified formecresol medicament combined with other materials, usually zinc oxide and eugenol, prior to restoring the tooth. Occasionally, removal is the only possible treatment.

Because of the child's age and the extensive treatment needed, it is often best to render the needed care in a hospital under general anesthesia.

In some cases, a dental prosthesis, a removable partial denture, may be needed. Several reasons for constructing a prosthetic appliance in even a very young child include: appearance (which can contribute to a negative self-image aggravated by the teasing of other children and even unthinking adults), habits such as tongue-thrusting and abnormal swallowing patterns with concomitant speech difficulties, delayed or altered eruption of permanent teeth and mastication difficulties.

Prevention

The physician who sees the expectant mother and then the young child has an opportunity that the dentist does not. He can inform the expectant and new mothers of the value of good eating habits and the potential harm that can result from putting the child to sleep with a nursing bottle containing any carbohydrate fluid. The child's physician should examine the teeth once they begin to erupt for signs of dental disease and refer the child to the family dentist or pedodontist.

The physician can aid in dental disease prevention by also instructing the mother to clean the teeth daily after they have erupted with a small, soft toothbrush or piece of gauze. It is also important that the child receive fluoride supplements should the area drinking water not contain the one part fluoride per million parts water that is recommended for dental caries prevention.

A pamphlet—Nursing Bottle Mouth—is available from the Order Section, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611. Prices are \$1.15 for 25 copies, \$4.20 for 100 copies and \$20.05 for 500 copies. This pamphlet is suitable for expectant parents as well as parents of newborn children.

Acknowledgments

The author thanks the following individuals for their assistance: Frederick Magaziner, DDS, for his suggestions in the writing of this article and Paul D. Biederman, DDS, Assistant Professor of the Department of Pedodontics of the Baltimore College of Dental Surgery of the Dental School of the University of Maryland, who is also a Diplomate and Fellow of the American Academy of Pedodontics, for the photographs used. □

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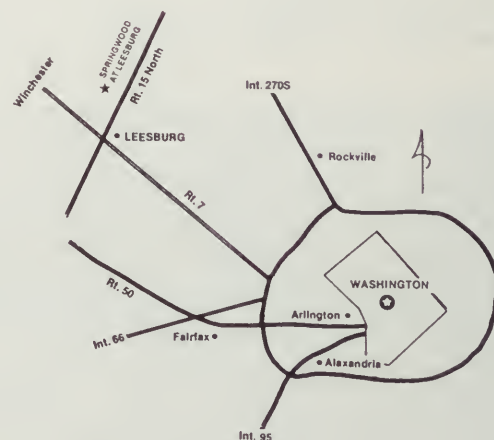
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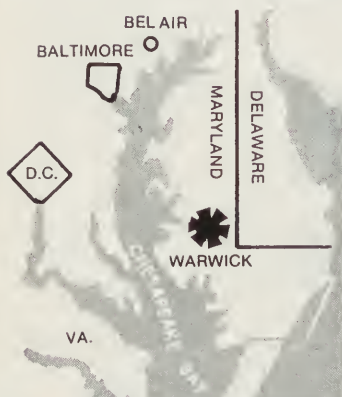


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Perforation of Uterus With Saf-T-Coil

By H. MELVIN RADMAN, MD

For reprint and other data, contact Dr. Radman at 3601 Clarks Lane, Balto., MD 21215.

Perforation of the uterus with a plastic contraceptive device has been encountered and reported since the resurgence of that mode of contraception.¹⁻³ The complication of accidental penetration has proved to be potentially dangerous on occasion and, at times, life-threatening.^{4,5} A variety of measures has been advanced in order to avert or minimize that type of accident. The incidence rate has been reported in various medical publications as from 0.2 to as high as 10 per 1,000 insertions.⁶ Penetration of or through the uterine musculature is believed to be related to the difficulties of insertions and is seldom caused by spontaneous migration. Ansari,⁴ in his study of the intrauterine device with a missing tail, lists some of the factors involved. He believes that accidental perforation occurs most frequently when the device is inserted by an inexperienced physician. Other reasons may be assigned to an unexplained soft consistency of the uterus, such as in the early postpartum period or subinvolution. Uterine displacement, cervical or uterine anomaly must be considered as causative factors. Failure to identify the tail of the device should be followed by instrumental uterine exploration and radiologic procedures, notably hysterosalpingography. If there is definite evidence of extrauterine location, removal of the apparatus should be accomplished by laparoscopy, laparotomy or posterior colpotomy—whichever is the most feasible and dependent upon the location and the extent of involvement of adjacent organs. The importance of the recognition of uterine penetration is emphasized by the following case report.

Case Report

This 23-year-old para 11001 was seen on June 30, 1976 with a history of irregular bleeding and abdominal pain. She had had a spontaneous delivery approximately 12 weeks prior to this consultation. Four weeks following the delivery, a Saf-T-Coil was inserted. At the time of insertion, she experienced marked abdominal and pelvic pain. Since that time, the pain has persisted, accompanied by episodes of irregular vaginal bleeding. There were no positive somatic findings. Examination of the pelvis revealed the string of the coil protruding through the cervix. The uterus was small, in anterior position and there was no evidence of adnexal pathology. Because of the discomfort and bleeding, the patient requested that the device be removed. The attempt was accompanied by lower abdominal and pelvic pain, and was unsuccessful. A flat film of the abdomen was taken, and the device was reported to be within the uterine cavity. Another attempt was made to remove the Saf-T-Coil under anesthesia. That was also unsuccessful. As a consequence, a hystrogram was done. Examination of the films revealed the device to be extrauterine and appeared to perforate the uterus

and to be lodged in the layers of the broad ligament. Exploratory laparotomy was chosen as the method of removal, since it was felt that adjacent organs were involved. At operation, the coil was found protruding through the uterine wall at the junction of the internal os and corpus. The omentum and small intestines were adherent to the loops of the coil; however, there was no evidence of injury. The coil was removed with ease and the laceration of the uterus was repaired. The postoperative course was uneventful and she was discharged from the hospital in seven days.

Discussion

While perforation of the uterus by an intrauterine device has been reported extensively, the case history presented accentuates the potential hazard of that accident. Studies have shown that the polyester spiral or loop causes only superficial endometrial reaction thereby causing little serious infection. Recent reports, however, fail to substantiate that claim. The older metal rings provoke a traumatic tissue reaction which predisposes to local infection, thereby weakening the uterine wall, and permits erosion of the device. Despite the efficiency, usefulness and encouraging results of those devices, that type has been discarded because of the concomittant dangers. A delay in the insertion of a plastic intrauterine apparatus should be emphasized so that the uterus is completely involuted and near physiologic size. In the nonpostpartum patient, the optimum time probably would be at the last day of the menstrual period. A careful pre-insertion evaluation of the pelvic organs to determine the direction of the utero-cervical canal and the depth of the uterine cavity are important preliminary steps. Correct insertion requires prior knowledge of those factors.⁷ If difficulty is encountered, the procedure should be discontinued. Perforation of the uterine wall with a plastic device may be a more serious complication than simple penetration of the uterus at curettage, since adjacent organs may be more readily injured.

Whenever in doubt, surgical exploration or laparoscopy should be performed.

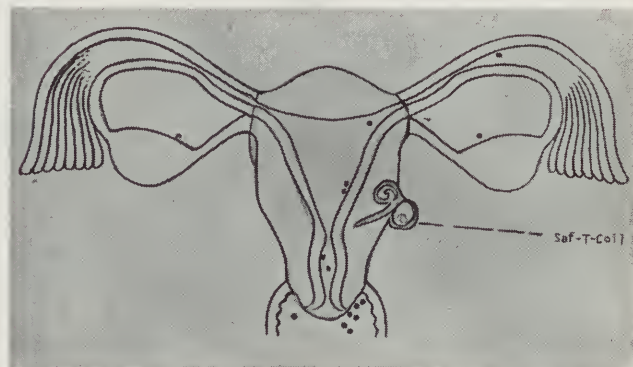


FIGURE 1

Diagram that reveals perforation of uterus by Saf-T-Coil.

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...in the functional bowel/irritable bowel syndrome*

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(dicyclomine hydrochloride USP)

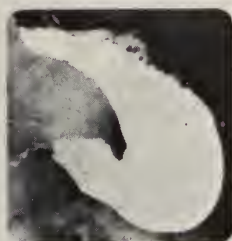
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

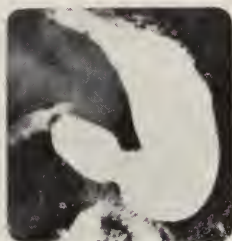
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

“The correlation of spasm relief and drug given was excellent.”

*This drug has been classified “probably” effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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Doctors in the News

Travellers Aided by City Hospitals Scientists

Montezuma's revenge—traveller's diarrhea—is often thought to be one of the unavoidable risks of traveling in a developing country. Now a group of scientists headed by R. Bradley Sack, MD and David A. Sack, MD, of Baltimore City Hospitals and the Johns Hopkins Medical Institutions, has found that an antibiotic called doxycycline can prevent most episodes of traveller's diarrhea when taken in daily doses. Moreover, the protective effect seems to last about a week after the drug is stopped.

According to an article in a recent issue of the *New England Journal of Medicine*, doxycycline has several advantages over other antibiotics in the prevention of traveller's diarrhea. It has a long half-life, which means that only one daily dose is needed, an advantage to travellers.

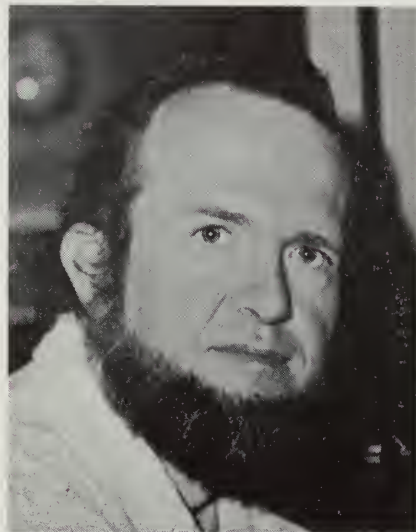
The scientists studied 39 Peace Corps volunteers during their first five weeks in Kenya. The volunteers took either doxycycline or a placebo for three weeks, beginning on their flight to Nairobi, and were observed for an additional two weeks. Nine of the 21 taking placebo and only one of the 18 taking doxycycline had traveller's diarrhea during the treatment period

or for one week after the drug was stopped.

The researchers warn that although this study demonstrated a marked protective effect, they do not recommend universal use of doxycycline for all travellers to developing countries; rather, use needs to be individualized. Specifically, long-term use is not recommended, nor is treatment of children who are at risk for dental staining. Also, they warn that doxycycline would probably be ineffective in the prevention of salmonella or shigella infections. Finally, they add that only one dosage schedule (100 mg. daily) was used and that perhaps a lower or less frequent dose might be equally effective.

Traveller's diarrhea is most often caused by a bacterium called enterotoxigenic *Escherichia coli* (*E. coli*, for short)—a toxic relative of the usually harmless nonenterotoxigenic *E. coli* bacterium which inhabits everyone's gut. An infection by the toxic form of *E. coli* causes the familiar symptoms of traveller's diarrhea; watery stools, cramps, vomiting and fever.

The work was carried out in cooperation with the Division of Geographic Medicine, Baltimore City Hospitals and the Johns Hopkins University School of Medicine in Baltimore, the US Peace Corps and the National Public Health Laboratory, both of Nairobi, Kenya; the National Institutes of Health, Bethesda, MD and the World Health Organization Collaborative Center for Reference and Research on *Escherichia*, Copenhagen, Denmark. □



R. BRADLEY SACK, MD

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Metabolic and Nutritional Assessment in Adult Surgical Patients

By CONSTANTINOS P. CHILIMINDRIS, MD, FACS

Dr. Chilimindris is Surgical Director of the Intensive Care Unit of the Greater Baltimore Medical Center, 6701 N. Charles St., Towson, MD 21204. This paper was presented at the 48 Annual Meeting of the Southern Society of Clinical Surgeons at Baltimore, MD in April, 1978.

Optimal nutrition is not only difficult, but, at times, almost impossible to achieve in the debilitated hospitalized patient. Periods of relative or complete anatomical or functional disruption of the alimentary tract frequently accompany a patient's primary pathological process and may assume primary importance in his clinical course, further compounding existing nutritional problems by precluding adequate enteral feeding. In too many instances, the patient must endure excessive morbidity and may, in fact, succumb not from his primary disease, but rather from the complications of secondary starvation.

Recent experience with nutritional problems in hospitalized patients has led into the recognition of two chief entities—hypermetabolism and starvation. Within the past decade, considerable progress has been made in understanding many biological processes relating to trauma, stress and metabolism.¹ Our complete understanding of the pathophysiology of the various components of stress has led to attempts to provide nutritional and metabolic therapy as part of an overall approach to the patient and his illness.

Hypermetabolism

Patients who demonstrate hypermetabolism have, as a rule, been subjected to extreme degrees of acute and prolonged stress (major injury, major operation, sepsis, burns, pancreatitis). Injury or severe acute illness initiate a stereotypic homeostatic response in the central nervous system, signalling for appropriate physiologic and endocrine adaptations to maintain body function and preserve vital organs. The relationship between the endocrine and metabolic response is complex and depends on many factors whose roles have not been fully clarified; however, the endocrine response is vital for normal recovery and convalescence. The central nervous system is of prime importance in the mechanism which initiates the all encompassing endocrine response to stress.² Following trauma or elective surgery, the afferent stimuli reaching the central nervous system are a combination or summation of these components which initiate the final common pathway. The magnitude of the response is directly related to the strength of these stressful stimuli.

Our view of the post-traumatic metabolic response has shifted increasingly from that of a phenomenon designed solely to restore hemodynamic homeostasis to one which restores nutritional homeostasis as well. Two concepts are central to maintaining a supply of en-

dogenous substrate for the patient in stress:

- 1) The inter-relation between the ventromedial and the ventrolateral nuclei of the hypothalamus which control the regulation of food as well as the directional flow of substrate from body stores, and
- 2) The two hormones of the pancreas, insulin and glucagon.

Linking these two systems are the autonomic nervous pathways, which in the case of the sympathetic nerve fibers, originate from the ventromedial nucleus, and in the case of the parasympathetic fibers, originate in the ventrolateral nucleus. Stimulation of the ventromedial nucleus by stress leads to hyperglycemia, inhibition of insulin secretion and a rise in the levels of glucagon, growth hormone, catechols and cortisol.³ (See Figure 1). The relative deficiency of anabolic hormones, together with the relative excess of catabolic hormones secondary to stress, ensures adequate and rapid mobilization of endogenous substrates from body stores for the utilization of cell metabolism and the ultimate survival of the patient.⁴ Amino acids are needed to meet the energy requirements of the individual and also to supply substrate for protein synthesis in the healing wound. In stress, gluconeogenesis is marked, as is shown by the increase in urine nitrogen excretion that persists despite zero nitrogen intake. Insulin is under the dual influence of catecholamines and nutrients. Norepinephrine is released from the sympathetic nerve endings innervating the islets of Langerhans secondary to stress; it inhibits insulin release leading to low absolute levels of circulating insulin. This favors increased amino acid efflux from peripheral skeletal muscle. Glucagon secretion is also under the influence of catecholamines, and stress induces a rapid increase in glucagon secretion. Glucagon's main site of action is on the liver, where it enhances trapping of the gluco-neogenic amino acids, stimulates gluco-neogenesis and the de novo syn-

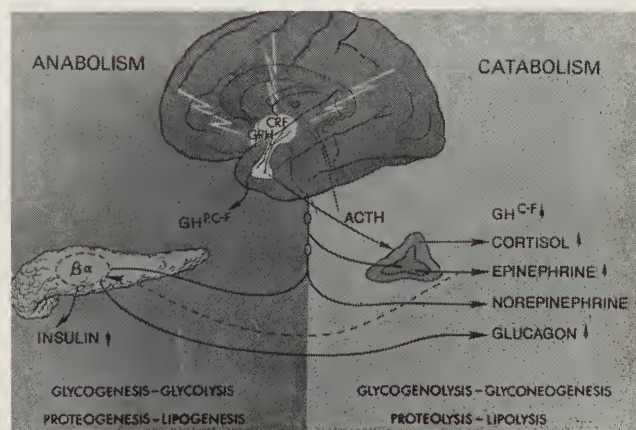


FIGURE 1

thesis of glucose from lactate, pyruvate and glycerol. As a result of gluconeogenesis, there is an increase in the urinary excretion of nitrogen moiety as urea and ammonia. A concomitant occurrence is the increase in the excretion of creatine and creatinine as well as bulk wasting of muscle mass as a consequence of proteolysis. Thus, high glucagon concentrations acting in conjunction with relatively-low insulin concentration ensure a steady supply of glucose, free fatty acids and ketones during situations of stress at the expense of body protein. This loss is reflected in the high urine nitrogen excretion.⁵

Starvation

Starvation is most common in hospitalized patients and may be recognized as mild, moderate or severe. It usually follows the abeyance of the hypermetabolic state, cancer, intestinal fistulae, chronic inflammatory bowel disease, chronic infection and many other debilitating medical diseases which render patients unable to sustain a normal nutritional state. Starved patients characteristically demonstrate chronic weight-

loss, protein/calorie malnutrition, anorexia, normal or low blood sugar, normal insulin levels and low-blood urea nitrogen. An example is the patient with stenosing carcinoma of the esophagus, who may have suffered chronically from dysphagia and not eating an adequate diet for a prolonged period. Such a patient often presents to the hospital with a significant weight-loss. In addition to the correction of anemia and serum protein and vitamin deficiencies, partial or complete restoration of an adequate or normal nutritional status should be contemplated for this kind of patient. Patients with other malignancies of the gastrointestinal tract, such as carcinoma of the stomach, colon and pancreas, also may fall into this category, as may patients with benign lesions leading to partial obstruction of gastrointestinal continuity, such as distal esophageal stricture or duodenal ulcer. Patients who have lost roughly 10% or greater of their body-weight should be treated with parenteral nutrition when possible prior to a planned operative intervention. Depending upon the situation, the duration of this therapy may be as short as five

Table 1
Group 1
Patients Operated on Without Pre-Op Nutritional Support**

No. Patients	Diagnosis	Operation	Complication	No. Pts.
6	Head and Neck Ca.	Composite	Pneumonia, Slough skin flaps	(3)* (2)
4	Esophageal Ca.	Colon Bypass	Sepsis, Pneumonia	(2)*
2	Abd. Aortic Aneurysm	Aneurysmectomy	Pneumonia, Renal Failure	(2)
3	Pancreatic Ca.	Biliary Bypass	Abdominal Sepsis	(2)
5	Inflammatory Bowel Disease	Bowel Resection	Anastamotic Leak	(2)
9	Colorectal Ca.	Major Resection	Sepsis, Dehiscence, Organ Failure	(4)
3	Bladder Ca.	Ileal Conduit	Anastamotic Leak, Organ Failure	(1)*
4	Enterocutaneous Fistula	Resection	Abdominal Sepsis, Wound Infection	(2)
36				20

*One death

**Received TPN after complication occurred

Group 2
51 Patients Treated with TPN One-Three Weeks Prior to Surgery

No. Patients	Diagnosis	Operation	Complication	No. Pts.
9	Head & Neck Ca.	Composite	Slough Skin Flaps	(1)
11	Rec. Genital Ca.	Pelvic Exenteration	Pelvic Sepsis	(1)
6	Rec. G.I. Ca.	Major Resection	Post-Op Ileus	(2)
13	Ca. Colon	Colectomy	None	
3	Peptic Ulcer Disease	Gastric Resection and Vagotomy	None	
6	Inflammatory Bowel Disease	Bowel Resection	Wound Infection	(1)
3	Enterocutaneous Fistula	Resection	None	
51				5

Table 1 Analysis of 87 patients with evidence of weight-loss on admission, 10% of body-weight or greater, who underwent elective operation at GBMC from Jan. 1-Dec. 31, 1977.

days or as long as two weeks. There is certainly a strong rationale for this therapy from the standpoint of decreasing the incidence of complications secondary to poor wound healing as exhibited by anastomotic and wound disruptions.⁶ Furthermore, in the starved state, man's immunologic defense mechanisms are depressed and, therefore, his resistance is diminished to a variety of infections in the wound, the respiratory tract and in other locations.⁷ (Table 1.) If nutritional deprivation is corrected preoperatively, it is felt that the debilitated patient is better able to withstand the major surgical procedure required for correction of his disease and is afforded a lessened incidence of complications from that procedure. Patients treated preoperatively are best continued on parenteral nutrition therapy throughout the operation into the postoperative period until restoration of normal gastrointestinal function allows resumption of an adequate diet.

There are several categories of non-surgical patients who may derive benefit from supportive parenteral nutritional therapy. Patients receiving chemotherapy or radiotherapy for cancer often suffer debilitating side effects from both of these primary therapeutic entities that can be severe enough to prevent continuation of the therapy. In addition, patients receiving radiotherapy to the region of the abdomen may develop inflammatory processes within the gastrointestinal tract itself, which may prevent oral nutrition. Patients in this latter category may be treated with bowel rest and supportive parenteral nutrition. The side effects of cancer chemotherapy may also be ameliorated by supportive parenteral nutrition which provides a normal or relatively normal nutritional status and allows the continuation of the therapy in the presence of anorexia, nausea and vomiting.

Nutritional Assessment

Based on the metabolic changes that occur during stress, starvation and injury, Blackburn et al⁸ have described relatively simple methods whereby changes in body composition and body proteins can be measured.

Lean body mass and fat stores are measured by anthropometric measurements (mid-upper arm circumference, triceps skin fold, mid-arm muscle circumference and creatinine height index). Depletion of the visceral protein compartment in stress conditions is measured by a depression in the secretory proteins-serum albumin, serum transferin and total iron-binding capacity (TIBC).

Since a large number of malnourished patients are hypermetabolic, the increase in energy expenditure can be estimated by the 24-hour urinary urea nitrogen excretion. At the same time, measurement of 24-hour urinary creatinine for creatinine height index can be carried out and nitrogen balance determined by the formula: Nbal = (Nitrogen in) - (Nitrogen out) = (Protein intake in gms ÷ 6.25) - (urinary urea N + 4*) (*4 = constant for skin + fecal + urinary non urea N.)

The cellular immune system is estimated by: (i) estimation of total lymphocyte count (L-cell function) expressed by the formula:

% lymphocytes x WBC
100

(ii) delayed cutaneous hypersensitivity to common recall antigens (T-cell function). (mumps, Candida, PPD, SK/SD streptokinase/streptodornase). Syringes are prepared with 0.1 ml. of each solution just before intradermal injection. All tests are administered by one person and the diameter of induration (in millimeters) at 24 and 48 hours after injection is measured and recorded by the same observer. The skin test is considered to be positive if the diameter of the induration at either reading is 5 millimeters or greater. The patient is then classified according to his response as normal (two or more positive), relative anergy (one positive) or anergy (no positive response). Cell-mediated immunity is an important host defense system against infection, and its depression is associated with increased morbidity and mortality from infectious disease in man. In a recent study of 250 patients, Meakins et al⁹ showed a significantly higher incidence of sepsis and mortality in patients with abnormal skin tests as compared to normal responders. Of the group of patients who either remained normal or whose responses became normal, the sepsis rate was 10%, and the mortality rate was 8%; however, a sepsis rate of 57% and a 78% mortality rate were found in those patients who developed abnormal response or whose responses did not improve. Anergy or relative anergy were found to be associated with malnutrition, sepsis, shock and trauma. In the clinical setting, effective treatment with total parenteral nutrition was associated with reversal of the anergic state and an improved prognosis. Nutritional immune competence can be substantially restored after two-three weeks of adequate nutrition, which although impressive, reemphasizes the time required for nutritional repletion. (See Figure 2.)

Thus, anthropometric measurements, determination of visceral proteins and cellular immunity and estimation of the degree of hypermetabolism constitute an essential series of basic steps prior to the institution of nutritional support. (See Table 2.)

Choice of Therapy

The type of nutritional support to be provided to a patient is most accurately determined by first categoriz-

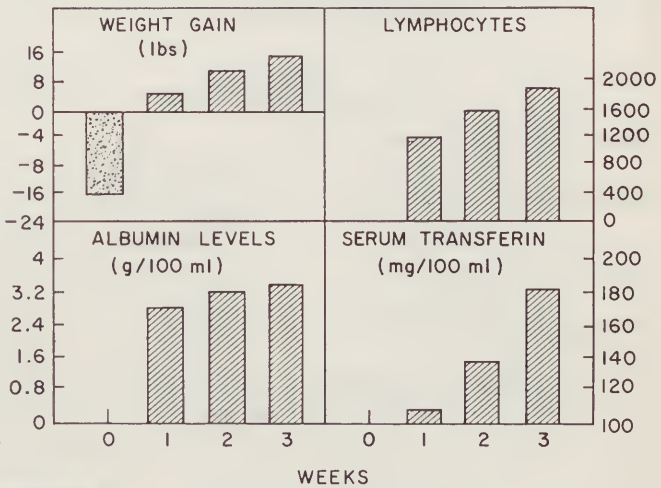


FIGURE 2: Response to nutritional support in 51 malnourished patients treated at GBMC. These parameters represent the best criteria for assessment of the efficacy of nutritional therapy.

ing the degree of depletion and/or hypermetabolism. (See Figure 3.) It is evident that, depending on the individual patient requirements and comprehensive nutritional assessment, a wide transition zone is present which allows flexibility in managing such nutritional problems utilizing the presently available regimens:

(i) 5% or 10% Dextrose

(ii) Protein-sparing therapy with hypocaloric peripherally-administrated amino acids for short-term mild-to-moderate depletion

(iii) Total parenteral nutrition (TPN) for hypermetabolic and severely-starved patients

(iv) Forced enteral feeding if the gut is functional. The response to such therapy is not immediate, there-

NUTRITIONAL ASSESSMENT SUMMARY

Patient _____ Room _____ Physician _____ Date _____

Service _____ Diagnosis _____

Admission Weight _____ Height _____ Ideal Weight _____

PARAMETERS	PATIENT VALUES	ASSESSMENT		
		>90% Standard* Not Depleted	60-90% Standard* Moderately Depleted	<60% Standard* Severely Depleted
Weight/height	kg cm			
Triceps Skin-fold (TSF)	mm			
Mid-Arm Circumference (MAC)	cm			
Mid-Arm Muscle Circumference (MAMC) MAMC (cm) = MAC (cm) - [3.14 × TSF (cm)]**	cm			
Lymphocytes, total count	mm ³			
Albumin, serum	g/100 ml			
Total Iron Binding Capacity (TIBC)	mcg/100 ml			
Transferrin Serum transferrin = (0.8 × TIBC) - 43**	mg/100 ml			
Urinary Creatinine	mg			
Creatinine Height Index (CHI) $CHI = \frac{\text{Actual Urinary Creatinine}}{\text{Ideal Urinary Creatinine}} \times 100^{**}$	%			

*See reverse for assessment standards.

Hematocrit _____ % Hemoglobin _____ g/100 ml Cellular Immunity: ☐ Positive ☐ Negative

Dietary Intake Evaluation: Calories _____ Cal/24 hr Protein _____ g/24 hr

Protein Status: Nitrogen Balance = $\frac{\text{Protein Intake} - (\text{Urinary Urea Nitrogen} + 4)^{**}}{6.25}$ ☐ Positive ☐ Negative

Nutritional Status: ☐ Marasmus (M) ☐ Kwashiorkor (K) ☐ Combination M-K ☐ Normal

Proposed Nutritional Therapy: _____

Table 2

fore, an adequate time period must be allowed prior to expected benefits from nutritional support.

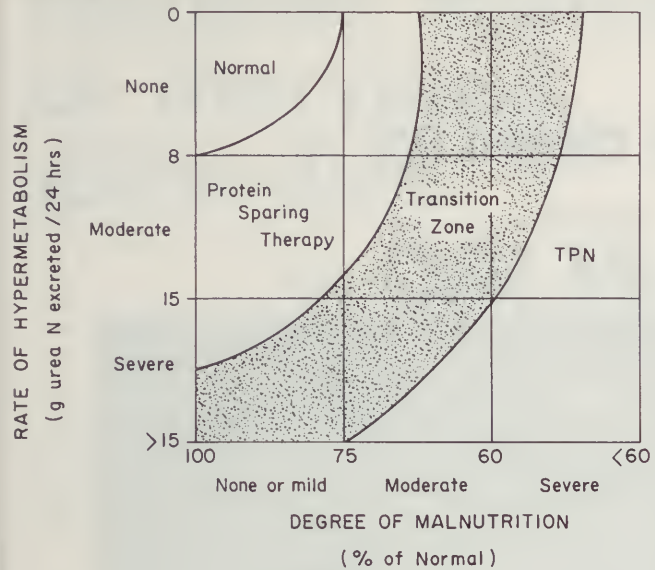


FIGURE 3
After Blackburn.

Summary

1. The endocrine and metabolic responses to stress and starvation are outlined.
2. Nutritional assessment of hospitalized patients with evidence of hypermetabolism and/or weight-loss of 10% of body-weight or higher should be considered.
3. Abundant evidence of increased incidence of sepsis, morbidity and mortality is demonstrated in recent literature in nutritionally-depleted patients.
4. Individuals suffering from protein/calorie malnutrition, depletion of visceral proteins and evidence of immuno incompetence should not be subjected to elective surgery, radiotherapy or chemotherapy until such changes are reversed with appropriate metabolic and nutritional support.

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Medical Annals of Maryland, 1899-1925

Edited by
L. H. MILES, Managing Editor
Maryland State Medical Journal
1971-74

Pharmacology in Maryland Through 1925

By JOHN C. KRANTZ, JR., PhD

Editor's Note: Dr. Krantz was Chief, Bureau of Chemistry, Department of Health, State of Maryland, at the time this article was written in 1932. His current address is Gibson Island, MD 21056 and he is Professor Emeritus, Department of Pharmacology, University of Maryland School of Medicine.

Introduction

In the year 1526 the great physician and miracle worker Paracelsus visited the City of Basel. The message of this timely iconoclast marked an epoch in the history of the medical sciences. In his cocksure, bombastic style he thundered: "The real object of chemistry is not to make gold, but to prepare medicines."¹ And the shock of his thunder reverberated through the medical world, enlisting the science of chemistry in the warfare against disease.

The rise of organic chemistry during the latter half of the past century, and the ever-increasing number of plant principles which were isolated, created an urgent demand for an adequate trial of these new substances as therapeutic agents. To meet this emergency, the science of Pharmacology was created. It is a fundamental science, a combination of biological and physical science, a science that bridged the chasm between the maker and the prescriber of medicines, a science so comprehensive that today it touches all of the ramifications of medical practice.

Abel at Hopkins

It is indeed coincidental that the history of Pharmacology in Maryland parallels the history of the science in America. For Pharmacology as a science in America began with the appointment of John J. Abel as Professor of Pharmacology in the Johns Hopkins University in 1892. He came to Baltimore as one of the members of the original faculty when the medical school of the university was opened in 1893. Although, at the University of Michigan, Abel was engaged in Pharmacological work, the chair in this institution is called "Materia Medica and Experimental Therapeutics."

The far-reaching influence of Abel's appointment in the Johns Hopkins University is evidenced by the fact that many of the leading chairs of pharmacology in the universities of this country are occupied by the pupils of this professor, the Dean of American Pharmacology.

Prior to the appointment of Abel to his post at the

Johns Hopkins University, the professorships of Pharmacology were not as a rule considered of sufficient importance to justify the incumbents' devoting their full time and effort to the work. These positions were generally held by pharmacists who had studied medicine and inadvertently drifted into the field. The viewpoint of these men was narrow and, because of the limited training on the part of those working in the field, the realm of Pharmacology was very markedly circumscribed.

In view of these existing conditions, Abel's coming to Johns Hopkins was in direct antithesis to the conditions extant in that day. He was thoroughly trained in the biological and physical sciences and was inured by working for years under such European master scientists as Carl Ludwig, Schmiedeberg, von Nencke and Naunyn.² Besides, Abel was thoroughly imbued with the tremendous clinical significance of Pharmacology. This basic and comprehensive scientific training, and the influence of associating with men representing the preclinical medical sciences, as well as the master clinicians, are made manifest in the various ramifications of this pioneer's research attainments.

Research Stimulus

The discovery of a pressor principle in the adrenal glands by Oliver and Schaefer in 1894³ stimulated the interest of physiologists in general in this field of research. Among those attracted to this then comparatively virgin field of investigation were Professor Abel and his associates. Abel and Crawford⁴ succeeded in separating the active hormone from the adrenal glands in the form of a polybenzoyl derivative in 1897. Abel assigned the formula $C_{17}H_{15}NO_4$ to the compound.

In the autumn of 1900, Takamine visited Abel's laboratory and became interested in the separation of the new product and conceived of simplifying the process. Takamine returned to his own laboratory⁵ and prepared concentrated extracts of the glands and by the addition of ammonia (the agent that had been regularly employed by Abel to precipitate free epinephrin after saponifying his polybenzoyl compounds) obtained burr-like clusters of crystals. These crystals were not, however, identical with the active principle isolated by Abel. Takamine named his product "adrenaline" and assigned the formula $C_{10}H_{15}NO_3$ to the compound. As

it was shown later by Aldrich,⁶ the compound isolated by Takamine was epinephrin, but in a somewhat impure form. Aldrich showed that Abel had isolated the benzoyl derivative of epinephrin and if this group ($C_6H_5.CO.$) is subtracted from the formula assigned by Abel to the compound, we obtain the formula $C_{10}H_{10}NO_3$ which is close to the formula of epinephrin.

Perhaps it was the pioneer nature of Abel's research which prevented his obtaining epinephrin in the form of the free base as prepared by Takamine. Having obtained the pure benzoyl derivative, he suspected that this group could not be removed without serious modification of the molecule. These circumstances militated against this forerunner in scientific progress and permitted the isolation of the pure principle to slip from his hands, but today the scientific world recognizes the basic and fundamental character of Abel's contribution to this discovery, and he is given the full credit for having isolated the first hormone. It was Maryland's first great epoch-making contribution to the science of Pharmacology. A third of a century of clinical trial with this dependable therapeutic agent testifies to the utilitarian value of this discovery. Besides, it has been one of the most powerful tools ever placed in the hands of the physiologists to unravel some of the problems of circulation and metabolism.

Reid Hunt

It is of special interest to reiterate that just about the time Abel was in the process of the isolation of epinephrin, Reid Hunt working in his laboratory made another discovery which was destined to be of striking importance as far as knowledge of the suprarenal glands is concerned. Hunt⁷ succeeded in demonstrating the presence of a depressor substance, not choline in an aqueous extract of the glands. He showed that it differed from choline by virtue of its exhibiting a depressor action on dogs after the administration of atropine. This substance, believed by Hunt to be a precursor of choline, produced a definite depressor action when as little as 0.003 mgm. per kilo was administered. Later, this substance was proved to be acetylcholine, perhaps one of the most therapeutically-active compounds that can be produced synthetically.

Dohme and Caspari

The manufacture of dependable and standardized therapeutic agents is one of the great contributions of Pharmacology to the practice of medicine. A. R. L. Dohme of Baltimore and Charles Caspari, Jr. made a contribution of far-reaching significance in this field. Caspari was the enterprising Professor of Pharmacy in the then Maryland College of Pharmacy. Dohme had attained a doctorate in chemistry from the Johns Hopkins University and had studied abroad under the masters in his field such as Gerock, Fresenius and others. These two investigators, in a comprehensive study, showed the possibility of using titration procedures in the evaluation of vegetable drugs for their alkaloidal content and hence their therapeutic efficacy. The methods devised by Caspari and Dohme⁸ made it possible to evaluate by comparatively simple chemical procedures the therapeutic value of such dependable drugs as

nux vomica, belladonna, cinchona and opium. The fact that the methods of standardization devised by these investigators were recognized by the United States Pharmacopoeia of 1900, and thus made obligatory in pharmacy, will stand as a lasting tribute to the Pharmacology of Maryland.

Maryland College of Pharmacy

It is interesting to deviate for a moment from the history of Pharmacology to interject a brief history of pharmacy in the state on account of the close affiliation and interdependence of these fields of science. Just at this period, 1904, the Maryland College of Pharmacy, organized in 1840, became an integral part of the University of Maryland under the name of the Department of Pharmacy of the University of Maryland. This school has been outstanding in its effort to raise the status of pharmaceutical education. In fact, one of its distinguished faculty members, Henry P. Hynson, issued the first call in 1900 for a meeting of those interested in pharmaceutical education. This resulted in the organization of the American Association of Colleges of Pharmacy.

At the turn of the century, the Department of Pharmacy had associated with it Charles Caspari, Jr. as Professor of Pharmacy. Besides his contributions to alkaloidal assays, Caspari was the author of a *Treatise on Pharmacy*, a justly-famed textbook. He was one of the authors of the *National Standard Dispensatory* and distinguished himself in several revisions of the *United States Pharmacopoeia*. In 1917 at his death, the chair in Pharmacy was occupied by E.F. Kelly, who succeeded Caspari as author of the textbook and played an important role in the establishment of ethical pharmaceutical associations in the state and nation. Kelly resigned in 1925 and John C. Krantz, Jr. was appointed Professor of Pharmacy.

David M. R. Culbreth for many years occupied the chair of *Materia Medica* in the Department of Pharmacy. His book on *Materia Medica and Pharmacology* enjoyed a considerable vogue in colleges of pharmacy and marked him as a man of national reputation. Culbreth lent his energies unstintingly to the establishment of a better understanding and more friendly feeling between the pharmacist and the physician.

In 1920, this college became known as the School of Pharmacy of the University of Maryland, when that institution merged with the state college. The school is now housed in adequate quarters. It has witnessed during the last quarter of a century the metamorphosis of retail pharmacy. Through this it has steadfastly set its course in the direction of sound ethics and lofty ideals for pharmacy. In 1925 Isaac Emerson, pharmacist and distinguished citizen of Maryland, endowed in this school a chair of Pharmacology which bears his name. The first appointment to this chair was that of Marvin R. Thompson, who is doing creditable work in the field of drug standardization.

More Research

Centering our attention again on the fundamental researches which have emanated from Professor Abel's laboratory, we are attracted by the work of Abel and

Ford in 1906.^{9,10} These workers carried out extensive investigations to discover the principles present in the poisonous mushroom, *Amanita phalloides*, known in French literature as "the destroying angel." Ford had shown previously that this fungus contains two separate principles, one a hemolysin and the other a non-hemolytic toxin. Abel and Ford isolated the hemolysin and discovered that the substance was a nitrogenous sulphur-containing glucoside. The toxin was also isolated and found to contain sulphur and nitrogen. This latter substance accounts for the lethal character of the fungus when ingested.

The poisons obtained from toads have been used by Indian tribes in their warfare. It was generally employed on arrow tips and spearheads. In fact, in the beginning of the 18th century, toad poison was used in explosive shells. In 1911, Abel and Macht¹¹ began an extensive pharmacological investigation of the constituents of the creamy secretion of the glands of the skin of the large tropical toad, *Bufo Aqua*. Abel then investigated the substance chemically. It is indeed singular that he should have found in this secretion a substance which showed itself to be identical with epinephrin, which he had isolated formerly from the adrenal glands. The moist secretion was found to contain as high as 6% of epinephrin. This discovery was fundamental, as it represented the first observation of a hormone being secreted as a constituent in an external secretion. Besides the isolation of epinephrin from the toad, through a thorough chemical study, Abel succeeded in isolating another principle from the skin of the toad. He named this substance "Bufagin." Pharmacologically, this crystalline principle showed itself to be a powerful heart stimulant, similar in action to the glucosides found in digitalis leaves.

Indeed, it is interesting in connection with this work of Abel and Macht to mention that almost two decades later, K. K. Chen, working in Abel's laboratory, made an intensive and important contribution to our knowledge of the pharmacology of the toad constituents. The title of the publication was *A Pharmacognostic Study of Ch'An Su, the Venom of the Chinese Toad*.¹²

The pioneer physician and explorer, David Livingstone,¹³ first suggested the use of arsenic in the treatment of African sleeping sickness, a disease known now to be caused by the "Trypanosoma Gambiense." Later, Breinl¹⁴ used tartar emetic, an antimony-bearing compound, with a degree of success in the treatment of this infection in rats; however, in 1910, Abel and Rowntree¹⁵ made a brilliant contribution to the chemotherapy of antimony. They prepared antimony thioclycollamide and antimony sodium thioglycollate. These compounds were tested on rats, rabbits and dogs inoculated with trypanosomes. The results were so impressive that the compounds were recommended for use in the treatment of human trypanosomiasis. These drugs have played an important role in the treatment of this serious malady; but, in addition to the use of Abel's compounds in the treatment of African sleeping sickness, Randall¹⁶ employed the drugs in the treatment of a tropical disease known as *Granuloma Inguinale*.

This contribution of Abel to Maryland Pharmacology

has been looked upon as marking a definite step in the progress of chemotherapy. Besides, it possibly stimulated the workers of later years in the production of Bayer 205—a potent trypanocidal drug devoid of any toxic metal.

Maryland Publications

While Professor Abel and his collaborators were engaged in these various fields of scientific endeavor, another lasting contribution to Pharmacology emanated from this laboratory. Abel was quick to realize that the organization and correlation of the rapidly pyramiding contributions to the basic medical sciences were of paramount importance. Accordingly, in 1905, in conjunction with the late Dr. Christian A. Herter, Abel organized the *Journal of Biological Chemistry*. Today, this publication stands as one of the foremost scientific periodicals of the world. Four years later, he founded the *Journal of Pharmacology and Experimental Therapeutics*, of which he remained editor during its nearly quarter of a century of successful service to pharmacologists and physicians. Thus, the pharmacologists of Maryland may well pride themselves in the fact that in their field of science most of the investigations originating in this country are published in their own journal, which now has become the property of the pharmacologists of the world. Besides these far-reaching activities in the publication of scientific work, Professor Abel was instrumental in the founding of the American Society of Biological Chemists and American Pharmacological Society. Each of these organizations today is flourishing and prolific in its contribution to the biological sciences.

Phthalein Dyes, etc.

Abel's interest in clinical medicine was evinced by his investigations in 1910 with Rowntree on the phthalein dyes. These two investigators discovered that phenolsulphonphthalein prepared by Ira Remsen was excreted solely by the kidney. Although in this investigation Abel was searching for a purgative that could be administered subcutaneously or intramuscularly after laparotomies, he failed to find such a drug; but with his scientific alacrity, he immediately suggested the use of the dye as a diagnostic agent in functional disturbance of the kidney. Rowntree and Geraghty¹⁷ carried this work to a successful conclusion by the development of the so-called renal function test, which depends upon the capacity of the kidney to secrete phenolsulphonphthalein after injection of the dye. For two decades, this test has remained as a most valuable and dependable diagnostic procedure in the hands of the urologist.

Indeed, this diagnostic test originating in Abel's laboratory was the precursor of the functional liver test. Within a few years after the discovery of the kidney function test, Rowntree et al¹⁸ used phenoltetrachlorphthalein to measure the functional activity of the liver.

It was in this period that Professor Abel began his classical researches on vividiffusion.¹⁹ He succeeded in devising an apparatus by means of which blood from a living animal could be diverted from its circulation through a series of dialyzing tubes. The blood was then returned to the circulation of the animal. During its

passage through these diffusion tubes, the blood loses by dialysis small molecules such as amino acids and glucose. On the other hand, the large protein molecules and the blood corpuscles remain in the circulating blood. It was by means of this apparatus that Abel and his associates were able to demonstrate the presence of many diffusible compounds existing in a free state in the blood which prior to this time were not known to exist in the circulating blood. Here, for the first time, definite proof was given that the amino acids exist in the free state in the circulating blood and not in a bound form as polypeptides or coagulable proteins. Abel's first announcement of these findings was made at the spring meeting of the Association of American Physicians in Washington in 1913. Abderhalden later substantiated the results of Abel and his co-workers after Abel and Rowntree had given public demonstrations of their method in the summer of 1913 both in London and in Groningen. He isolated one new compound from the dialysates of circulating blood of dogs, namely A-isobutylhydantoin.

It is this vividiffusion apparatus of Abel which is so often referred to as the artificial kidney. Although not a preferential filter as the normal kidney, it is true that, by the proper adjusting of the nature and the concentration of the substances in the liquid surrounding the diffusion tubes, many otherwise diffusible substances can be made to remain in the circulation. In fact, Professor Georg Haas of Giessen has used the apparatus with certain modifications to alleviate the symptoms of patients seriously-ill with glomerulonephritis.

More Investigations

Within this same period a very important contribution to endocrinology as well as drug therapy was published from the Department of Pathology of the Johns Hopkins University. In 1909, MacCallum and Voegtlin²⁰ demonstrated the presence of a hypocalcemia in dogs from which the parathyroid glands had been removed. They further showed that the classical symptoms of tetany could be removed in these parathyroidectomized animals by the injection of soluble calcium salts. This work was the forerunner of the later work of Luckhardt and others in calcium therapy and from this the use of organic salts of calcium such as the lactate and gluconate became rational therapeutic agents.

By the year 1910, Abel's laboratory had become a veritable mecca of pharmacological investigations. Many scientists interested in drugs and the extraction of hormones came to work in the professor's laboratory and imbibe from him his unquenchable and unconquerable passion for scientific investigation. Chemists, clinicians, pharmacologists have sat at the luncheon table in the professor's laboratory where he freely and modestly discussed and evaluated contemporary scientific work. Little did these men realize that, as disciples of the great teacher, they would be the leaders in the Pharmacology of the next decade.

David I. Macht

One of the most interesting and indefatigable workers who associated himself with Professor Abel was David I. Macht. Macht distinguished himself as a

scholar in the public schools of Baltimore and at the Johns Hopkins University, where he later studied medicine. This brief account of the Pharmacology of Maryland has already mentioned his name as collaborator with Abel in the pharmacological investigation of "Bufagin," but Macht, himself, soon became interested in a variety of lines of research which, within a quarter of a century, have touched on many of the fundamental medical sciences as well as contributed to various clinical phases of medicine.

Perhaps the most significant and thorough investigations contributed by Macht²¹ were his pharmacological studies of the opium and belladonna alkaloids. Through a comprehensive study of the chemical constitution of these alkaloids in comparison with their action on smooth muscle, Macht was led to believe that the benzyl group common to many such compounds was responsible for much of their antispasmodic activity. Accordingly, he recommended the use of benzyl alcohol and certain benzyl esters as therapeutic agents. For more than a half-decade, these compounds enjoyed a considerable vogue as antispasmodic drugs in the hands of many clinicians. Later work²² showed that what was considered to be a specific effect of the benzyl group is an effect that can be produced by many alcohols of high molecular weight.

Dr. Macht, a thorough student of the Bible, examined some of its folklore and edicts by means of scientific experiments. Perhaps one of the most interesting investigations of this nature was his work with Lubin²³ in 1923. He interested himself in the biblical injunction of the purification of menstruating women. He discovered a toxin in the perspiration of menstruating women, which was not present at other times. This toxin inactivated yeast and caused the rapid withering of flowers. Besides it was toxic to the protoplasm of certain seedlings. It is unfortunate that Macht did not finish this work and bring this most promising investigation to a convincing conclusion by the isolation of some definite chemical principle shown to be responsible for the biological results observed.

Later, Macht became interested in developing the field of phytopharmacology in which he and his co-workers used the seedlings of lupinus albus as test objects upon which to determine the presence of toxins²⁴ in blood serum and to measure quantitatively the potency of certain drugs.²⁵ This method has been shown by various workers to be valuable in qualitatively detecting the presence of toxins or other bodies which have a deleterious action on plant protoplasm. Quantitatively, the method warrants further study; perhaps the greatest criterion of its accuracy and significance could be ascertained by a critical statistical study.

In the early Twenties, Macht became interested in the physical factors which influence the potency of drugs. He studied the influence of various radiations on different drugs which led him ultimately to an extensive investigation of the action of plane-polarized light on drugs. Macht²⁶ published many articles on this most interesting subject and pointed out many possible practical applications of his findings, yet there seems to be a diversity of opinion among the workers²⁷ in this field

as to the actual influence of polarized light as a deteriorating effect on drugs. Recently, a European investigator pointed out that one of the optical isomers of a brominated aliphatic hydrocarbon was completely destroyed under the influence of circularly-polarized light, while the other isomer remained unaffected. More experimental work will be necessary to determine the ultimate nature and significance of these observations.

Macht has contributed more than 300 communications to Pharmacology and related sciences published in many of the leading scientific periodicals of the world. During the quarter century period covered by this treatise, he distinguished himself as one of Maryland's most prolific contributors to scientific literature.

More Researchers

Soon after Professor Abel had completed his work on vividiffusion, Kendall²⁸ in 1916 succeeded in isolating thyroxine, the second hormone to be separated as a pure chemical entity. About this time, Abel became interested in the active principle or hormone in the posterior lobe of the pituitary body. In 1919, through a series of extensive investigations, Abel and Kubota²⁹ demonstrated the presence of histamine in the posterior lobe of the pituitary body. By means of a more-or-less complicated extraction process, these workers succeeded in obtaining the dipicrate of histamine. They showed that the histamine picrate obtained from the pituitary body is identical with synthetically-prepared histamine picrate, in respect to crystalline form, melting point, solubility and physiological behavior.

In 1922, Abel and Rouillier³⁰ described a method for preparing a principle or hormone from the infundibulum of the pituitary gland, which exhibited an oxytocic activity equal to from 20 to 30 times its own weight of the acid phosphate of histamine. With numerous other investigators, Abel pounded away on the isolation of this active principle of the posterior lobe of the pituitary body. Other investigators associated with Abel in this study were Nagayama,³¹ Roca³² Campbell³³ and E.M.K. Geiling,³⁴ who became Associate Professor of Pharmacology under Abel.

Pituitary Gland

From the very first, the investigators who had concerned themselves with the pharmacology of the infundibulum of the pituitary gland had assumed a multiplicity of active principles: some postulating three and others four separate principles. In making these separations, the active extracts employed had been subject to rather drastic treatment with acids. Early in 1928, Kamm³⁵ and his associates succeeded in separating two of these principles from gland extracts, but did not succeed in isolating them as chemical entities. One B-Hypophamine was obtained as a pressor principle devoid of oxytocic action. The other B-Hypophamine, or the oxytocic principle obtained, was found to be 150 times as potent as pituitary powder. The B-Hypophamine is now known to possess antidiuretic as well as melanophore-expanding properties and, according to the prevailing view, does not consist of a pure pressor principle, but appears to be mixture of several principles. Abel³⁶ has given an analysis of the various actions of B-Hy-

pophamine in one of his recent papers. He still contends that the principle of the posterior lobe is one chemical entity responsible for both pressor and oxytocic activities. The subject remains an unsettled question and further investigational work must be conducted in order to solve the problem.

Working in Professor Abel's laboratory, Geiling³⁷ made a fundamental and important contribution to our knowledge of the physiology of the posterior gland. He showed that the intravenous injection into trained, unanesthetized dogs of relatively small doses of pituitrin and pitressin (the pressor fraction) produces for a short period a state resembling an anaerobic metabolism in the tissues drained by the superficial and deep veins of the dog. During this time the venous blood has an arterial-like color and oxygen content, a lowered carbon dioxide tension, a rapidly rising lactic acid, increased glucose and inorganic phosphate. This is the period of decreased cardiac output and lowered basal metabolism.

Following this stage of tissue asphyxia is the recovery period when conditions are reversed: an abnormally dark venous blood, increased utilization of oxygen and production of carbon dioxide by the tissues, and a continued rise and subsequent gradual return of lactic acid to the pre-injection level. In the jugular vein, however, during the stage of maximum action, the blood is more venous in character and has a decreased oxygen content. Direct measurement of the oxygen consumption of these dogs shows a striking parallelism between the gaseous metabolism and blood changes noted above.

With Grollman, similar studies were carried out on man with therapeutic doses of post-pituitary preparations and the results are in accord with those found in animal experiments. These results offer proof that the posterior lobe hormone is one of the important regulators of metabolism and also afford the basis for reconciling the discordant results of previous investigators who have interested themselves in the role of the posterior lobe secretion in metabolism. Geiling has investigated some of the pharmacological aspects of other endocrines, such as insulin, epinephrin and the anterior lobe of the hypophysis. He has laid special emphasis on work with unanesthetized subjects owing to the marked interference of anesthetics with the normal physiological functions in the animal organism.

Organic Dyes

In 1917, a chemist, E. C. White, associated himself with H. H. Young of the Brady Institute of the Johns Hopkins Hospital. Young was interested in studying the effect of organic dyes containing germicidal metals in the treatment of infectious diseases. In 1912, Geraghty had suggested the same problem to H. A. B. Dunning of Baltimore. Dunning did a considerable amount of work in the preparation of silver-containing phthaleins.

However, he did not carry the work to a satisfactory conclusion. White³⁸ prepared a number of azo mercurials and also phthaleins containing mercury. They found dibromoxymercurifluorescein to be the most promising of the series and it was studied clinically by various workers. Commercially, the disodium salt was marketed in 1920 under the name of mercurochrome. Young recommended mercurochrome for intravenous

injections in septicemias, but the drug is not generally accepted as being safe for intravenous medication. As an external antiseptic for cuts and abrasions, the 2% solution of the drug has enjoyed wide use, but, in addition to the utilitarian value of the drug, its success as a therapeutic agent heralded the production of a great number of new antiseptics; perhaps among these some day will be discovered the "Magna Therapia Sterilsans" of Paul Ehrlich.

In 1913, T. B. Johnson³⁹ of Yale prepared certain alkyl resorcinols and showed that the germicidal activity of these compounds increased as the number of carbon atoms in the aliphatic side chain was increased. In 1921, Lane,⁴⁰ in his PhD thesis working under Johnson, prepared butyl resorcinol. Accordingly, in 1922, it occurred to A. R. L. Dohme⁴¹ that it would be well worthwhile preparing those higher derivatives containing, five, six and seven carbon atoms in the aliphatic side chain. In conjunction with V. Leonard,⁴² it was shown that the compound having six carbon atoms in the side chain, namely hexylresorcinol, was most germicidal.

This compound was introduced into medicine as a urinary antiseptic of high germicidal capacity. Later, Leonard and Frier⁴³ found that the compound in glycerin-water solution markedly reduced the surface tension of the mixture and the substance became extensively employed as a local antiseptic. This interesting drug perhaps owes its principal utilitarian value as a local antiseptic to its comparatively non-toxic nature.

Department of Pharmacology

In 1920, the School of Medicine of the University of Maryland appointed W. H. Schultz as Professor of Pharmacology. This marked the beginning of a department devoted entirely to Pharmacology in this university. Schultz came with excellent training: a PhD in Physiology under Howell. In his department, O. G. Harne developed a very useful instrument used in pharmacological instruction. This apparatus is known as the University of Maryland Chronograph, and it enables the entire class of students to operate their pharmacological experiments with a central electrical control with the same ease as though one experiment alone were being conducted.

After the isolation of insulin by Banting and Best⁴⁴ in 1921 in the form of a therapeutically-active extract, Professor Abel, now a seasoned veteran in hormone isolation, turned his attention to this pancreatic hormone. Perhaps in this field, Abel's crowning achievement in Pharmacology was made. After extensive work, in 1926, Abel⁴⁵ announced the isolation of the pancreatic hormone in a crystalline form. Abel's crystalline insulin is characterized by its high labile sulphur content. This work initiated a brilliant series of researches in Abel's laboratory on the chemical nature of this substance. Abel⁴⁶ and his associates showed the empirical formula of the hormone to be $C_{45}H_{75}N_{11}S$. Further investigations in Abel's laboratory showed insulin to be a molecule that chemically can be classed as a protein. It marks the first isolation of a hormone that can be classified as a protein. Abel showed that his crystalline substance was decomposed by the ferments of the intestinal tract

and hence the possibility of oral administration seemed to be precluded.

Quarter-Century Close

This epoch-making discovery marks a fitting close to the quarter of a century of Maryland's contributions to Pharmacology. Space will not permit discussing the significant researches made by Abel's students among whom are Faust, Crawford, Hunt, Aldrich, Lowenhart, Barbour, Voegtlin, Rowntree, Lamson, Macht and Geiling. These men have moulded and shaped modern Pharmacology. Now in the twilight of life, the Professor stands, with the enthusiasm and courage of life's high noon, a veritable challenge to all of his students. Working daily with test tube, kymograph and pen, he is in Pharmacology as Dante said of Aristotle, "master among those who know."

Thus Maryland has served preeminently as the cradle of modern Pharmacology in America during the past quarter of a century. With the increasing number of new drugs and the ever-widening scope of this field of science, Maryland has endeavored to keep pace. One may predict with sufficient assurance for human purposes that when the next quarter of work is written, although many of the masters with us now will have passed on, their influence will dominate their students, and the Pharmacology of Maryland will again occupy a position of preeminence.

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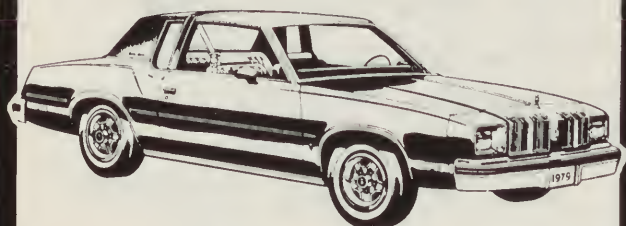


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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

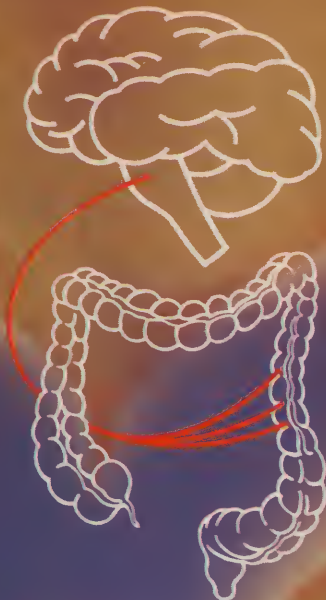
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Doctors in the News

Dr. Schumacher Tapped

Dale N. Schumacher, MD, has been named Assistant Chairman of the Department of Medicine and Director of Medical Care Studies at St. Agnes Hospital, Baltimore.

In this newly-created position, Dr. Schumacher will be working to better facilitate the practice of medicine at the Hospital by decreasing some of the administrative duties required of members of the attending staff.

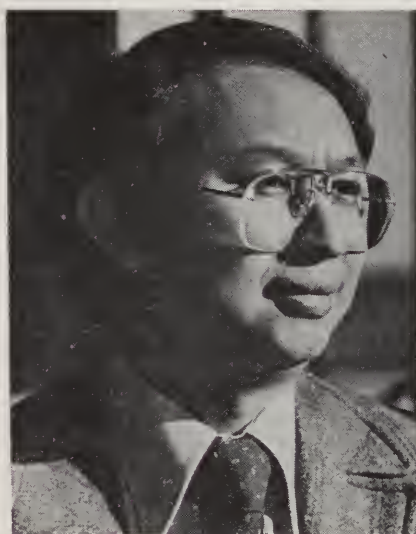
Dr. Schumacher will work with the Medical Audit Committee and assist in matters pertaining to the Professional Standards Review Organization. He will assist in recruitment of residents for the Department's training program and work as a liaison with the various regulatory agencies including the Maryland Health Services Cost Review Commission.

Dr. Schumacher holds a bachelor's degree from the University of Arizona. He received his MD degree from the University of Illinois in 1969, and one year later received a Master's Degree in medical education from the same institution.

He completed his Internship and Residency at a combined Johns

Hopkins-Baltimore City Hospital program. Most recently, he completed a three-year postdoctoral Fellowship at the Johns Hopkins University School of Hygiene and Public Health.

Dr. Schumacher is a native of Chicago. He is married to the former Barbara Parker, a Registered Nurse and an Instructor of Nursing at the University of Maryland. The couple resides in the Elkridge section of Howard County with their three children. □



DR. ZAW-WIN

Dr. Zaw-Win Picked

Dr. Bo Zaw-Win, formerly of Rangoon, Burma, has been named Assistant Medical Director of the Levindale Hebrew Geriatric Center and Hospital, it was announced recently by Levindale President Alfred I. Coplan.

The Medical Director is Dr. Noel List.

Dr. Zaw-Win, who emigrated to the US approximately five years ago, came to Levindale in 1975 after completing his Residency in Internal Medicine at Franklin Square Hospital in Essex, because of his particular interest in the specialty of Geriatrics. He has also had a year's internship at Doctors' Hospital in Washington, DC, with a two-months rotation at the Walter Reed Army Medical Center.

Dr. Zaw-Win did his undergraduate work at Rangoon University,

where he received his medical training at the Institute of Medicine, graduating among the top five of his class in 1969. Following graduation, he accepted a teaching post as Clinical Instructor in the Institute.

Dr. Zaw-Win received his early education at Christ Church Cathedral School in Oxford, England, while his father was serving as Burmese Ambassador to France.

Dr. Zaw-Win is an associate of the American College of Physicians and a member of the Gerontological Society. □

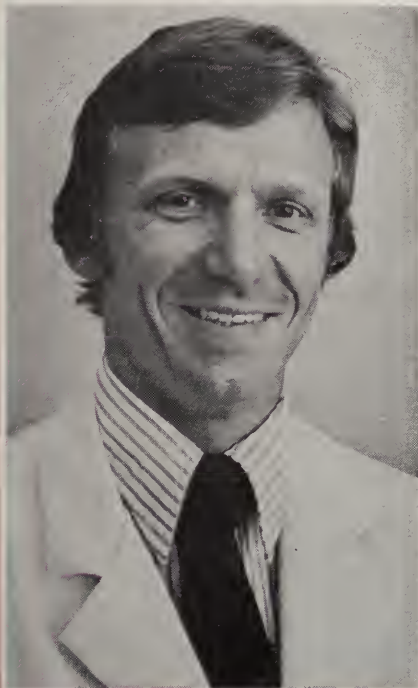
Dr. Rogers Named

Dr. Mark C. Rogers has been appointed Director of the Division of Pediatric Intensive Care at the Johns Hopkins Children's Center and of the Hospital's Pediatric Intensive Care Unit (PICU), the regional referral center for pediatric intensive care patients and one of the largest of such units in the country.

Trained in Cardiology, Anesthesiology, Intensive Care and Pediatrics, Dr. Rogers is introducing new approaches in the care of critically-sick infants and children at Hopkins. In particular, he has helped coordinate an expanded scope of care in the PICU to cover neurological problems, as well as the traditional areas of cardiac and pulmonary problems. According to Dr. Rogers, the PICU now has an organized team approach to the treatment of a whole range of conditions which may cause neurological (i.e., brain) damage in children, including trauma, meningitis, drownings and shock.

Working with neurologists and neurosurgeons, studies are being conducted to determine if new monitors can detect brain swelling early. Techniques to reduce that swelling are also being assessed to determine which treatment is most effective. Recent research has shown that increased intracranial pressure, or brain swelling, may be a major cause of neurological damage, Dr. Rogers explains. It seems that in cases where oxygen flow to the brain is cut, the brain begins to swell, further decreasing oxygen

(Continued on p. 73.)



DR. SCHUMACHER



THE MANY FACES OF DR. ALLEN

LEFT:

DR. ALLEN NAMED STATE SENATOR—Med-Chi member, Annapolis physician, former Republican member of the Maryland House of Delegates, GOP State Party Chairman and recently his party's candidate for the post of Lieutenant-Governor of the Free State, **Dr. Aris T. Allen** (seen in this photomontage by artist Claude Brooks) was recently named State Senator to represent Anne Arundel and Calvert Counties. The 67-year-old Annapolitan filled the vacancy created by the death of Sen. Edward T. Hall (R., 30th.) Dr. Allen was featured in a **Journal** cover story in its June, 1977 edition. He is seen at left with (clockwise) Juanita Jackson Mitchell, former Baltimore Mayor Thomas J. D'Alesandro (left), Anne Arundel County Executive Robert Pascal and former Maryland Gov. Marvin Mandel.

(Dr. Rogers . . . Con't. from p. 71.)
flow and further increasing the chance of damage to the brain, he says. Therapies, such as controlled ventilation, induced hypothermia—the cooling of the body below its normal temperature—and drug treatments may be effective in decreasing the swelling of the brain in severe conditions.

Dr. Rogers emphasizes the importance of treating critically-ill children in units specifically geared to their needs. "Medical procedures that are useful on adults can not always be used on children," he says. "There are a number of technical and medical considerations to be taken into account in the care of critically-sick infants and children. For example, they don't respond to stress as well as adults. This is why we need specialized units staffed with specialized pro-

fessionals to care for these young patients."

The PICU at Hopkins features sophisticated cardiac output machines, which can be used on infants as small as two or three pounds; sensitive monitoring equipment which constantly monitors pressures in the heart, blood vessels and head, specially-designed respirators and a highly-trained staff of doctors and nurses. "The nurse-patient ratio is 1:1, and at no time is a doctor more than 25 feet from a patient," says Dr. Rogers.

Dr. Rogers, who was educated at Columbia University and Upstate Medical Center in Syracuse, completed his training at Massachusetts General Hospital and Children's Hospital Medical Center (both in Boston), Duke University Medical Center and Harvard Medical School. Associated with Dr. Rogers

in the PICU is Dr. Stephen Nugent, who trained in Pediatrics and Intensive Care in Philadelphia, and Dr. James Robotham, of the Pediatric Pulmonary Division. □

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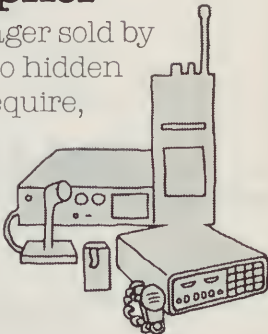
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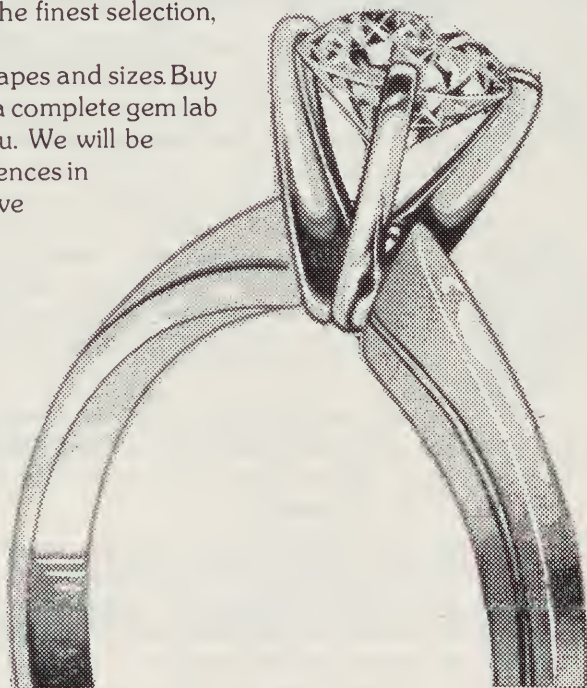
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Auxiliary

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Editor

Cecil County Auxiliary History

The Cecil County Auxiliary had its beginning sometime in the 1940s. The information is very sketchy. Interest faded and not until about 1962 did the Auxiliary reorganize. June Ross was President and the members became quite active and interested in helping the Cecil County Day Care Center get situated. A large cash donation was given by the Auxiliary to help with the new building. Millie Johnson was a strong supporter of the project. Another of our projects has been helping a young student from the area to enroll and graduate from a school that teaches rehabilitation and speech therapy.

We still take blood pressures at the local Courthouse one day a month. This has been our continuing project through the years. Many of the senior citizens in the area look forward to this monthly visit.

Our members meet the second Tuesday of each month for a dinner. Attendance is small, about five or six members. Many of our former active members have retired or moved to other areas. Many were from Perry Pt. and the now phased-out Bainbridge.

Each year, we have our family picnic at one of the members' homes. This is a fun time and our families get to know each other a little better.

Doctors' Day is still celebrated in Cecil County.

MRS. JOSEPH LANZI
President, Cecil County

Charles County Auxiliary History

In the Spring of 1977, several physician spouses met with the then-State President Helen Boyer and State President-Elect Carol Broadus for the purpose of forming a County Auxiliary. We chose temporary officers who worked over the summer to get support for this venture.

In October, 1977, we held our first meeting after having received approval from the President of the Charles County Medical Society, Dr. Chinmoy Banerjee. There were 15 people present. The basic structure of a county auxiliary was discussed and plans to move forward were made. Those present approved the first official officers: Nancy Howell, President; Marlene Kassem, Treasurer and Fatima Haziq, Secretary. Mrs. Haziq was later replaced by Christie Mason.

In January, 1978, we sent out a questionnaire to all other physician spouses who were not present at the October meeting. The response was less than we had hoped. This was to become the first in a long line of disappointments.



AUXILIARANS at FALL CONFLUENCE, Chicago, 1978 (left to right, seated): Mary Strauss, Connecticut President and President-Elect, Helen Anderson, Lillian Tumbusch and two S. Dakotans. (Standing, left to right) Vicky Kretkowski and Med-Chi staffer Kim Judy. (Auxiliary photo.)

On July 29, 1978, Nancy Howell and Marlene Kassem became instructors in CPR. This may well be our major contribution to the community as a group since we have given to course to approximately 100 people and had the whole month of January, 1979 booked with other courses. We ask for donations, which go to the Greater Waldorf Jaycees for the use of their equipment, and the rest will become a donation to the AMA-ERF. We are very proud of this accomplishment.

The Rotary Club of La Plata has approached us to assist it with the Arthritis Society of Southern Maryland in manning a hotline for questions and places of treatment.

We have also been asked to help with CME symposia in conjunction with the local hospital. Dr. Saad Kassem, the Education Chairman of Physician's Memorial, would like a program for the physicians, nurses and other health care personnel in our area. We would be assisting from the registration and strategical end.

Our most disappointing area has been the lack of membership. We would like to enlist the physicians of the County in this endeavor. If the doctors will recognize us and encourage their spouses to join us, we feel that we can accomplish much. We have the time and, if we desire, can expend the effort to do those things the doctor would like to do but cannot because of the lack of time. We are an AUXILIARY, an aide, a helper, an expansion of the main group. With more members, we can show the community what the medical sector can and does do for it. Without support, we will cease to exist. None of us wants that to happen.

We hope that as Charles County grows, more of the new doctors and their spouses will join our group of three. We won't give up and we hope no one else gives up hoping and praying for us.

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President, Charles County

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March 21, Psychotherapy and the New Psychiatry, talk by Jarl Dyrud, MD.

Apr. 5, Stages of Adult Development and Marital Stress, talk by Ellen Berman, MD.

May 3, Cancer, talk by Jimmie Holland, MD.

Apr. 20, Schizophrenia, talk by Geo. Winokur, MD and John Strauss, MD.

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March 14, Infectious Disease-Fungi, talk by Abe Macher, MD at 6:30 and on **Parasites** at 7:30 Martin Wolfe, MD.

March 21, Infectious Disease-Antibiotics, talk by Nigar Kirmani, MD and on **Bacteria** at 7:30 by Carmelita Tuazon, MD.

March 28, Viruses at 6:30 by Nathaniel Young, MD and at 7:30 **Dermatology** by Mervyn Elgart, MD.

Apr. 4, Vascular Heart Disease at 6:30 by Alan Wasserman, MD and **Coronary Artery Disease** at 7:30 by Douglas Rosing, MD.

Apr. 18, Cardiology—Arrhythmias, talk by Barton Gershen, MD at 6:30 and on **Conduction Defects** at 7:30 by Jorge Rios, MD.

Apr. 25, Cardiology—Non-Invasive Studies, talk by Alan Ross, MD at 6:30 and **Peripheral Vascular Disease** at 7:30 by Jos. Lindsay, MD.

May 2, Lipids, talk at 6:30 by John LaRosa, MD and **Hypertension** at 7:30 by Karl Wipplinger, MD.

May 9, Rheumatology 1, talk at 6:30 by Werner Barth, MD.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

March 12-16, Management of Obesity, for 32 cred. hrs. of AMA Cat. 1, Physician's Recog. Award.

March 15-17, J. Donald Woodruff Symposium on Gynecologic Oncology.

March 19-21, Spectrum of Developmental Disabilities in the Preschool Child: Issues in Detection and Trtmnt.

March 22-23, Diag. and Trtmnt. of Neoplastic Disorders.

March 26-30, Practical Cardiology for the Practicing Anesthesiologist.

March 29-30, College Mental Health Symposium, at the Homewood Campus in Balto. Approved for 15 cred. hrs. in AMA Cat. 1.

Apr. 2-7, Pediatric Trends, 1979.

Apr. 9-10, Psychiatric Update, 1979: Topics in Contemporary Psychiatry.

Apr. 17-20, 7th Anl. Symposium on Prac. Advances in Diag. Rad. and Nuc. Med.

Apr. 25-27, Wilmer Residents Assn.

Apr. 26-May 17, Seminar-at-Sea Diag. and Management of Common Neurological Problems, 14 days aboard ship including

Peking, Tokyo, Shanghai, Canton and Hong Kong for 42 hrs. in AMA Cat. 1 cred.

Apr. 30-May 2, Inst. on the Ministry to the Sick.

May 7-12, Topics in Clin. Med.

May 9-12, Clin. Update: 1st Anl. Chesapeake Bay Area Anesthesia Conf. for 17 hrs. AMA Cat. 1 cred.

May 14-18, Pathology of Bone and Joints.

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March 21, Trtmnt. of Sexual Aggression with Depro-Provera, talk by Michael K. Spodak, MD and Z. Ann Falck, RN.

Apr. 7, Adolescents in Turmoil 11th Anl. Psychiatric Symposium, 8 AM-evening.

Apr. 25, Emergency Rm. Psychiatry, talk by Michael Kamin-sky, MD.

University of Maryland

March 1-Apr. 5, Selected Topics In Family Practice, Univ. of MD at Baltimore, Sch. of Med., Sophomore Lecture Hall, Howard Hall Tower. Meets every Thursday 5:15-7:45 P.M. For additional info., contact the Prog. of Cont. Educ. Univ. of MD Sch. of Med. at (301) 528-3956.

March 9-10, Gastroenterology for Primary Care Physicians, Cross Keys Inn, Columbia, MD. For additional info., contact the number above.

Apr. 12, Eastern Shore Clin. Symposium on Oral-Head and Neck Neoplasia, Tidewater Inn, Easton, MD, 2 PM-mid-evening. For details, call Ms. Laura Brittingham at (301) 749-1624.

Apr. 19-21, 4th Anl. Cancer Symposium, Internatl. Hotel, BWI Airport. For details, call (301) 528-3956.

Apr. 26-27, Advances in Transfusion and Coagulation Biology, Annapolis Hilton Inn. Call (301) 528-3956.

May 11-12, Rehab. of Patients with Stroke and Hip Fracture, Deaton Med. Ctr., Balto. For details, call (301) 528-3956.

Other Maryland Meetings

March 29, The Adolescent w/ Heart Disease, 8:30 AM-4:30 PM, Cross Keys Inn, Falls Rd., Balto., MD. For details, call (301) 685-7074.

Apr. 4, New Trends in OB/GYN, talk by Gerald Glowacki, MD. For details, call Ms. Karen Lane, CMA-AC, (301) 821-5222.

April 27-28, Sexuality and the Cardiovascular Patient, Cross Keys Inn, Balto., co-sponsored by Amer. Heart Assn. Council on Clin. Cardiology; Amer. Heart Assn.-MD Affiliate; Amer. Heart Assn.-Central MD Chap. Accred. AMA, Amer. Acad. of Fam. Prac., Amer. Assn. of Crit. Care Nurses. For further information, contact Mrs. Michaeline Silverstein, Prog. Dir., Amer. Heart Assn.-Central MD Chap., PO Box 17025, Balto. MD, 21203; (301) 685-7074.

May 2, Pain Management talk by Vinod K. Bhalla, MD. For details, call Ms. Karen Lane at (301) 821-5222.

Amer. College of Physicians

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March 21-23, Update in Infectious Diseases, Med. Coll. of Pennsylvania, Sheraton Hotel, Phila., PA.

May 10-12, Decision-Making in Clin. Prac., Wash. Hosp. Ctr., Wash. Hilton.

May 16-18, Rheumatology for the Non-Rheumatologist, Univ. of Pittsburgh Sch. of Med., Pittsburgh, PA.

Other

Apr. 22-26, Anl. Drug. Rad. Update Post-Grad. Course, Charlottesville, VA. Fee: \$275. Contact: Theodore E. Keats, MD, Prof. and Chairman, Dept. of Radi., Univ. of VA, Charlottesville, VA 22901. Cat. 1-16 hrs.

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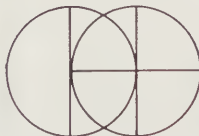
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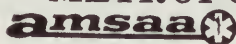
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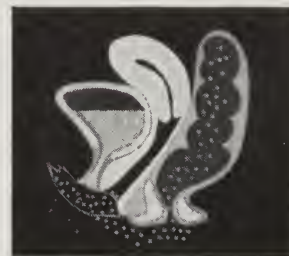
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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see reverse side for summary of product information.

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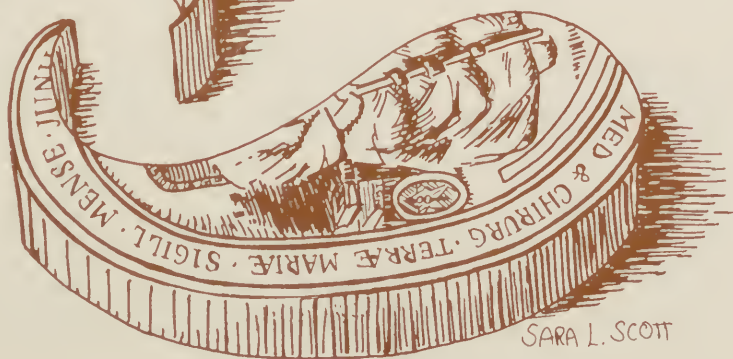
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the belief of the Chinese,
produced the universe and maintain
cosmic harmony." - - -

The New Modern Encyclopedia, 1950.

Should Med-Chi members
also be AMA members?



SARA L. SCOTT

Interviews with Drs. Russell Fisher, Charles O'Donnell and Stephen Padussis
help you decide . . . see page 35

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



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specimens, and confirmation of the positive TINE TEST using the Mantoux method. In general, the TINE TEST does not need to be repeated. Antituberculous chemotherapy should not be instituted solely on the basis of a single positive TINE TEST.

Adverse Reactions: Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.

Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.

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MARYLAND STATE MEDICAL Journal

Volume 28

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Number 4

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EDITORIAL and BUSINESS OFFICE:
211 Cathedral St., Baltimore, MD
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Class postage paid at Baltimore, MD.
Accepted at the special rate au-
thorized. Published monthly.
Subscription rates: US, US Pos-
sessions, one year \$8; elsewhere
\$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily
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DR. STEPHEN PADUSSIS, a long-
time Med-Chi member, is also a
dedicated AMA man. To learn why,
turn to page 35 in this issue. (Photo
by Mettee Photography, courtesy of
St. Agnes Hospital, Baltimore.)

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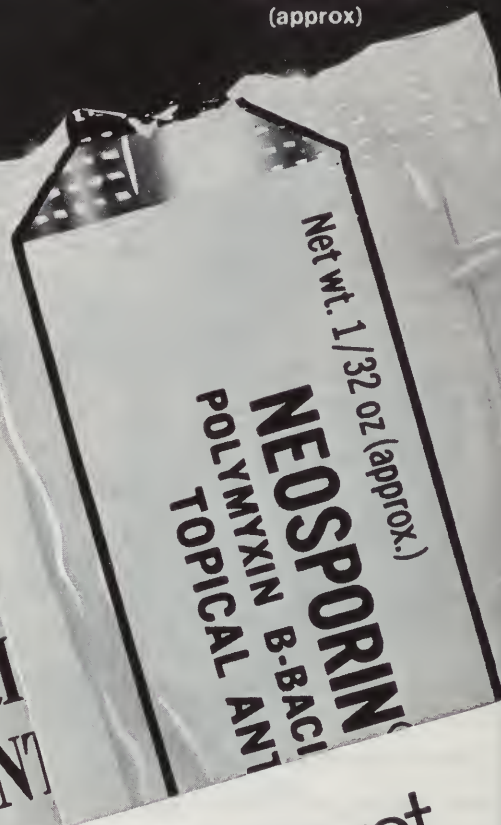
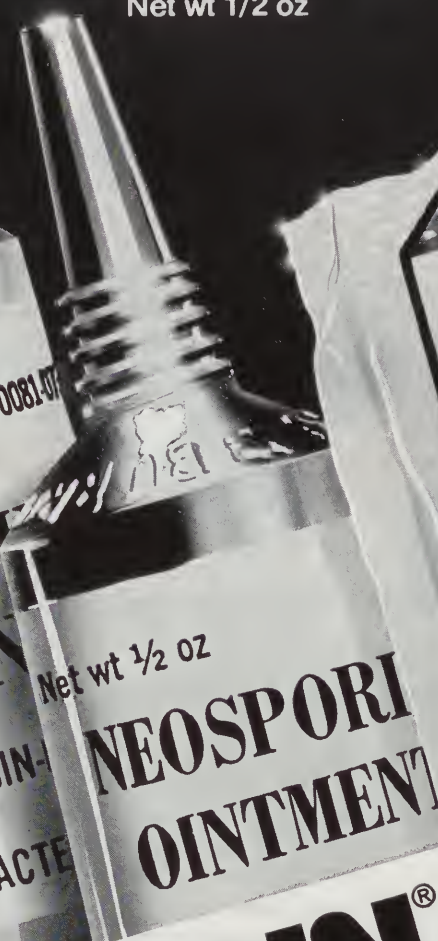
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ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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The Open Forum

From Dr. Solomon . . .

To the Editor:

With a great sense of pride, but with a feeling of genuine sadness, I have resigned from the position of Secretary of Health and Mental Hygiene, effective Jan. 16, 1979.

This should come as no surprise, since I stated in an interview in the *Journal* in January, 1978 that I would be leaving office prior to the inauguration of the new Governor. I reiterated this in a public statement which I issued on Sept. 16, 1978.

In leaving public office, I will have more time to devote to my private practice in helping people who want to lose weight, to my writing and to spending more time with my family. This is not to say that I shall not continue my interest in public health and with the delivery of health care. It is my intention to speak out "loud and clear" on these matters, perhaps even with a frankness that public office sometimes inhibited.

I am well aware that at times my stewardship has been controversial. I was not controversial for the sake of controversy, but because I felt strongly that health problems should be brought to the public so solutions could be forthcoming.

In other words, I was sensitive enough to care, but tough enough to fight. Never have I attempted to conduct a popularity contest, but have attempted to move programs along that would help all the people and that I would not be a pawn of any special interest or pressure group.

Perhaps I have received the greatest criticism for appearing on television. The local production, *Prescription for Family Health*, was, in my opinion, an excellent medium for health education. I would hope that something similar would again be aired. These programs brought to a Maryland viewing audience information that simply was not available elsewhere. The national television shows on which I appeared, all on my own time, brought to the state valuable publicity of a positive nature. My books also nurtured good medical

practice which was helpful to the state's image. The fact that certain elements of the press seemed to take an almost sadistic delight in being critical, has not altered my opinion that I have always acted in the best interest of the people of our state.

The much-publicized Dewberry Report, requested by Gov. Marvin Mandel, stressed only the negative aspects of the Department of Health and Mental Hygiene and neglected its many, many accomplishments. This may have been the mission of the Committee, but I frankly found it distasteful, as did many of my colleagues. The Report did, however, have its positive results, in that it reinforced our desire to expedite a continuing self-evaluation and brought about organizational changes which have improved the functioning of the Department.

The Department has, in my opinion, made remarkable progress since its creation in July, 1969, at which time I became Secretary.

The Department's staff is highly professional and devoted to serving the people of Maryland. I know that the new Secretary will find a group of individuals who are well-qualified and equipped to handle the multitude of programs and equally well-equipped to face the problems of the future.

The bringing together of a number of previously-independent Departments into a single umbrella agency was a monumental task, but I think this transition has been accomplished with a minimum of difficulty, and that the real purpose of the Cabinet system of government has been achieved. As to be expected, there were growing pains and, perhaps, the Department moved too quickly in centralizing its activities, but as an end result, the people of our state have been well-served.

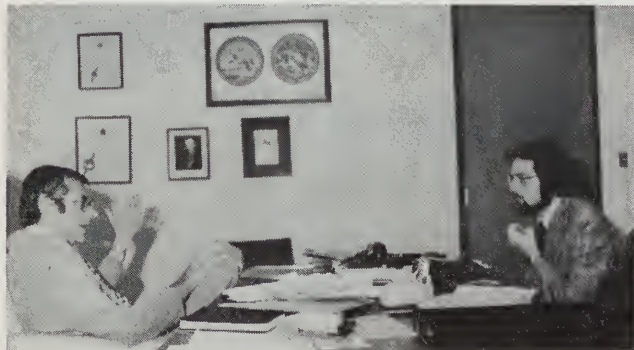
Today, there is a close working relationship between local Health Departments, local Health Officers and the Headquarter's staff of the Department. The "Maryland Public Health Team" is nationally-recognized as one of the strongest, if not the strongest, in the nation.

I am particularly proud of the gains made in the area of environmental health and the progress that has been made in reducing pollution of the air and water and in controlling problems for the disposal of solid waste.

Community programs dealing with mental hygiene, mental retardation and juvenile services have been accelerated.

I am gratified by the current leadership team in mental hygiene. These officials have brought a new outlook to the State's mental health program, with the recruitment of well-qualified individuals to work with the community, as well as keeping the Department's residential programs up to a reasonable standard.

In the field of mental retardation, a total, new emphasis has been applied. The previous medical model has been altered so that emphasis now has been placed on special education and training, permitting



DR. SOLOMON (left) being interviewed in late 1977 for the *Journal's* January, 1978 cover story by Managing Editor Blaine Taylor. (Photo by Claude Brooks.)

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the mentally-retarded to function at their highest possible level. Previously unacceptable conditions in some of the State's institutions, primarily Rosewood, have been corrected or are in the process of being corrected.

The programs dealing with preventive medicine, the aged and chronically-ill, laboratories and local health deserve special commendation.

The Department has won national acclaim for its progress in immunization against childhood diseases, aid for crippled children and proper nutrition for mothers and young children.

The Laboratory, in its new quarters on Preston St. in Baltimore, is one of the finest in the nation, turning out quality work, a hallmark for the rest of the country.

The Administration for Services to the Chronically-Ill and Aged has likewise expanded its programs to be of greater service, has upgraded its residential institutions and through its Geriatric Evaluation Program has been of greater assistance in the proper placement of the elderly.

Skillful programming and careful attention to appropriate administrative practices have enhanced the programs for drug abusers and those with alcoholism. These programs also have a close linkage with local groups and agencies.

Significant progress has likewise been made in dealing with juvenile offenders; not that we have reached the ultimate solution to this ever-present situation, but I believe the philosophy of rehabilitation is vastly superior to one of punishment and retaliation. The Department's stand in opposing a juvenile prison was one I am particularly proud of and it is my belief that the money which would have been wasted on such an institution is now being better-utilized in community programs.

The Medicaid program, which accounts for approximately one-half of the Department's budget, has been effectively managed with greatly-improved administrative procedures. This program provides medical care for approximately 400,000 of the state's poor and elderly, playing a major role in the State's system of delivery of health care.

Also worthy of note is the Department's program to upgrade the quality of care in nursing homes with more frequent and more effective inspections.

In looking to the future, the State and nation face numerous health problems which will require the best thinking and talents of our people. With some type of National Health Insurance looming on the horizon, it is incumbent upon all segments of the health industry to work together to provide an effective system at a cost that the nation can afford.

The ever-increasing escalation of health costs is a facet of the nation's economy in need of prompt and meaningful attention. Up until now, cost containment has been done in a piecemeal fashion without the coordination and public mandate that it really needs.

Within the state, its citizens must realize that resources are still not available to meet the pressing needs of multi-leveled programs embraced by the Department. If we are to reach our objective of quality

health care for all Marylanders, these additional resources must be made available.

If requested, I also intend to offer my full cooperation to the new Secretary and to the new State government. Gov. Hughes, as a former Cabinet Secretary, is well aware of the problems of bureaucracy and I am certain that he will deal with these problems in a practical and effective manner.

NEIL SOLOMON, MD, PhD
Formerly Secretary,
Dept. of Health and Mental Hygiene
State of Maryland



The COVER ARTIST this month is **Sara L. Scott**, a sophomore majoring in graphics at the Maryland Institute, College of Art, in Baltimore.

5TH ANNUAL FAMILY MEDICINE REVIEW COURSE

JUNE 3-9, 1979

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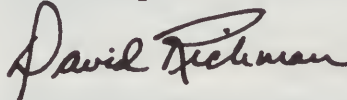
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Sincerely,



David Richman, Ph.D., R.Ph.
Director of Quality Assurance

DR:rcc

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M.H. Bortnick, B.S., R.Ph.

In Memoriam

Whitmer B. Firor, MD, 1902-79

Dr. Whitmer Bennett Firor, 76, the Faculty's President during 1960-61, died Jan. 18, 1979 at his Baltimore home after a long illness. Former Chief of Radiology at Baltimore's Union Memorial Hospital, Dr. Firor was also a former President of the Baltimore City Medical Society (1958).

One of the country's best-known specialists in his field, Dr. Firor was Assistant Professor of Radiology at the Johns Hopkins Medical School and served as Associate Editor of the *Year Book of Radiology* for 15 years. He also was the author of many papers in his professional field.

He served at various times as Chief of Radiology at the Sheppard and Enoch Pratt Hospital and the Women's Hospital, which is now part of the Greater Baltimore Medical Center. He also served on the staff of Children's Hospital in Baltimore.

Dr. Firor was a former member of the Medical Board for Occupational Diseases, which hears such cases for the State Workmen's Compensation Commission.

A graduate of the Johns Hopkins University, where he obtained a BA degree in 1923, and the Hopkins Medical School in 1927, he practiced his specialty here for nearly 35 years, retiring in 1974.

Born Apr. 23, 1902 in Scranton, PA, Dr. Firor was a son of the Rev. Marion L. Firor and Anna Percival Firor. The family later moved to Maryland and he grew up in Thurmont, in Frederick County.

As a young man, he played the violin. Although not an active musician in later years, he retained his interest in classical music and attended concerts regularly.

After obtaining his MD degree at Hopkins, Dr. Firor served his internship at the Henry Ford Hospital in Detroit, and his residency at the University of Michigan Hospital. While a resident, he was a University of Michigan Fellow in Radiology during 1929 and part of 1930, the year he moved to Baltimore and entered private practice.

Dr. Firor served in the Army Medical Corps during World War II, rising to the rank of Colonel, and was assigned to the 118th General Hospital, a Hopkins unit, at Ft. Meade in 1945 and part of 1946, after his return from the Philippines. He also served in Australia and

New Guinea.

He was a member of the Maryland and Elkridge Clubs, the American Medical Association and the American Roentgen Ray Society.

Married in 1928 to a Canadian nurse at Hopkins, Mildred Isabelle Conley, Dr. Firor fathered a son, Whitmer B. Firor, Jr., MD of Saskatoon, Sask., and three grandchildren.

The late Dr. Firor was also a man of humor, as evidenced by a handwritten note at the end of an autobiographical sketch penned for Med-Chi files: "Take this, add salt, boil, simmer down to proper level."—BT.



DR. FIROR
(Photo by Udel, Balto.)

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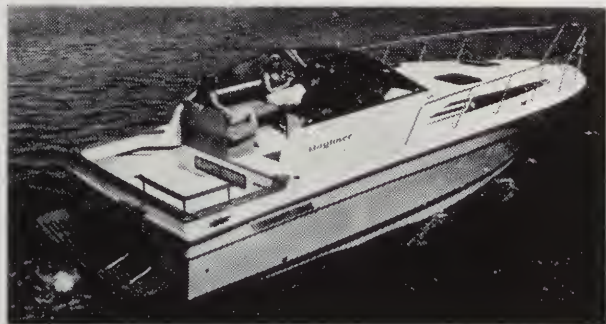
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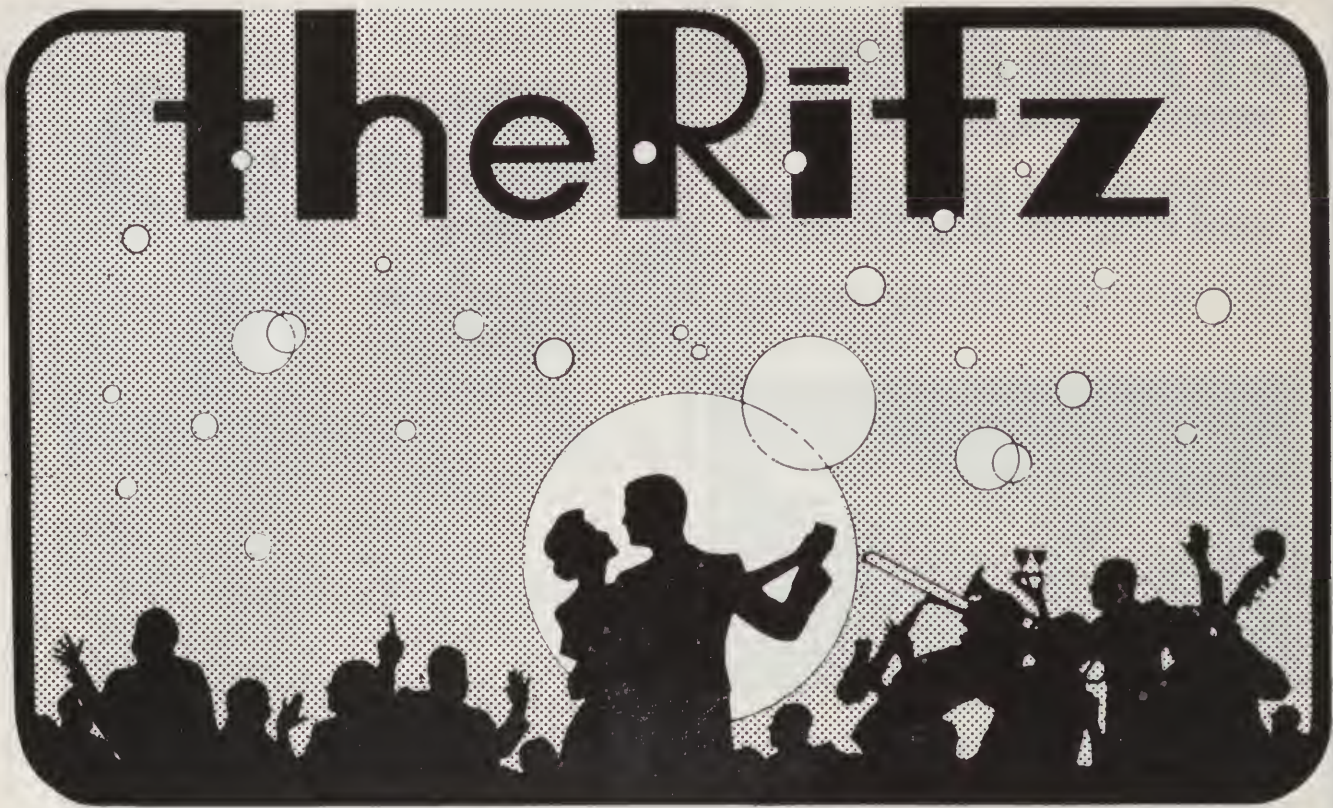
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Executive Director's Newsletter

April, 1979

ANNUAL

MEETING

INFO

No resolutions were received in the Faculty office by Friday, March 16, the deadline for receipt of resolutions. Therefore, there will be no Reference Committee meeting nor will there be a report of this committee presented to the House of Delegates at the annual session.

Reports in the mail to Delegates, Alternate Delegates, component society officials and officers of the Faculty include the Bylaws Committee report, containing various minor bylaw amendments. Along with this is a tentative agenda for the House of Delegates sessions on Wednesday, May 2 and Saturday, May 5. The length of the scientific programs this year requires a meeting of the House of Delegates on Saturday.

The annual Presidential Banquet will be held on Friday evening, May 4, marking the close of the scientific programming and other activities.

SEMIANNUAL

MEETING DATES

The Faculty's Semiannual Scientific Meeting will be held in New Orleans, Louisiana, from September 12 to September 16, 1979. The House of Delegates session will be held in Baltimore on Saturday, September 29, at the Faculty Building.

LEGISLATIVE

ACTIVITY

The 1979 General Assembly session will adjourn at midnight, Monday, April 9, with over 1,812 House bills and over 1,122 Senate bills having been introduced. The Faculty's legislative agents followed over 300 of these bills.

Testimony was presented in support or opposition to over 100 of these bills, with either the legislative agents or Faculty officials speaking on the issues raised.

The Faculty worked closely with statewide specialty societies in presenting its testimony. An expression of thanks goes to those members who willingly contacted their Delegates and Senators on issues before the General Assembly, when requested to do so by the Faculty.

HUMANITIES

SEMINAR

April 16 is the deadline date for receipt of applications from physicians and others seeking to participate in the Humanities Seminars. These sessions are tuition free and carry with them a \$1,200 stipend to cover expenses. Details can be obtained through the Faculty office.

STATE SOCIETY

DUES

A recent study by the AMA reveals that Maryland ranks 40th in the amount of state society dues. The figures, based on 1979 dues structures, show a high of \$420 in the District of Columbia and a low of \$100 in Connecticut. The dues median for 1979 is \$200. Sixteen state societies increased their dues in 1979 ranging from a 20% increase to a 67% increase. The District of Columbia jumped to first place in dues amounts from sixth in 1978.

Maryland's dues are \$160 plus a \$10 assessment for the building fund, which is assessed for a set period of time only, on each new member.

JCAH

SURVEY

SCHEDULED

JCAH surveys are scheduled for the period of April through June, 1979, of the following hospitals:

Baltimore City Hospital
GBMC
Johns Hopkins Hospital
Sinai Hospital.

Any individual aware of "problem" situations at any of these institutions is requested to communicate with the JCAH on the subject. Data should be sent to John E. Milton, Deputy Director, Hospital Accreditation Program, 875 North Michigan Avenue, Chicago, Illinois, 60611, telephone (312) 642-6061.

HISTORICAL

TRIVIA

When telephones were first developed and became a means of communication in the Baltimore area, the Faculty was assigned the three-digit number 872. When exchanges came along, the Faculty was assigned 9-0872; and finally, when three digit prefix numbers came into use, the Faculty was designated 539-0872. The Faculty has retained the same telephone number ever since it was first assigned.

MOCK

ARBITRATION

SYMPOSIUM

A mock arbitration symposium will be held on Thursday, June 7, 1979, from 7 to 10 PM in the Freshman Lecture Hall at the University of Maryland School of Medicine, in cooperation with the University of Baltimore, MICPEL, School of Law, the University of Maryland School of Medicine and the Health Claims Arbitration office. Anyone interested in participating may contact the Faculty office for further details. The registration fee is unknown at this time.


Executive Director

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Council

The Council met on Jan. 25, 1979 and took the following actions:

1. Observed a moment's silence in memory of M. McKendree Boyer, MD, of Damascus, MD and C. Willard Camalier, MD, of Washington, DC, both of whom died since the last Council session. Also adopted motions of appreciation for the time and effort of these physicians in serving the profession and the public.

2. Granted 1979 dues waivers for two physicians on account of illness.

3. Approved changing the September, 1979 Council meeting date from the 22nd to the 29th, to avoid a Jewish holiday on the previous date.

4. Rereferred two recommendations to the Committee on Preventive Medicine and Public Health dealing with 1) banning the use of trampolines in schools and 2) utilizing EMTs at scholastic sports events. Both recommendations involve obtaining additional information and clarification.

5. Accepted a report from the Med-Chi Insurance Trust regarding insurance coverage for emotional illness and instructed the Trust to offer this supplemental coverage to participants in the Med-Chi programs.

6. Approved a list of nominees for submission to Maryland Blue Shield for consideration of its Nominating Committee.

7. Adopted a revision in personnel policies dealing with overtime. The addition is as follows:

Overtime: Overtime is required of employees as necessary.

Compensatory time off or wages, in accordance with Federal laws, will be provided for non-exempt employees only.

When an exempt employee works overtime exceeding three hours beyond normal working hours, reimbursement will be made for any expenses incurred for meals. Such reimbursement will be on the basis of actual expenses incurred up to a maximum of \$12.50 for dinner.

Travel expenses: When employees are traveling on Faculty business, reimbursement for meals not included in the meeting registration fee will be made on the basis of a maximum of \$25 per day. This maximum is computed on the basis of \$5 for breakfast, \$5 for lunch and \$15 for dinner. All expenses must be itemized indicating which, if any, meals were included in the meeting registration fee.

8. Approved a site for the 1980 Semiannual Meeting, but then reversed the decision, asking the Program and Arrangements Committee to consider other locations

and dates for recommendation to the Council.

9. Adopted the budget for 1979.

10. Recognized the following physicians for their lengthy and devoted service on the Peer Review Committee:

Katherine H. Borkovich, MD

Edward J. Kowalewski, MD

11. Authorized the President to name an Ad Hoc Committee to review present payment policies by health insurers wherein they pay a facility fee for service only when rendered in a hospital. Common sense would indicate that total payments under such a program could be reduced if a facility fee were available to encourage physicians carrying out such procedures in an office setting.

12. Rejected the concept of establishing a counter-suit fund which would finance countersuits against attorneys who file non-meritorious claims against physicians.

13. Approved expenditure of \$975 to underwrite costs of radio talk shows by physicians over WBJC-FM, for an additional 14 weeks.

14. Endorsed the following health status goals as suggested by the Central Maryland HSA:

Objective #1: To reduce the deaths from cirrhosis from 16.8 per 100,000 to 15 per 100,000 by 1981 and maintain that level of decline.

Objective #2: To reduce the morbidity of alcohol abuse as measured by hospital admissions for alcohol.

Objective #3: To reduce the morbidity for alcohol abuse as measured by hospital admissions for alcohol intoxicification.

Objective #4: To reduce the incidence of fetal alcohol syndrome.

Objective #5: To reduce the number of alcohol-related traffic deaths.

Objective #6: To reduce incidence of alcohol-related child abuse.

15. Referred to the Health Planning Committee a question raised by the Central Maryland HSA that would require hospitals to provide educational programs on alcoholism, with mandatory attendance by physicians and other health personnel. The Committee will consider and report to the Council on this subject.

Executive Committee

The Executive Committee met Feb. 8, 1979 and took the following actions:

1. Deferred action on a suggestion the Statewide PSRO Council involve itself in the review of in-hospital patient care quality, until such time as the Chairman of this Council could be heard from.

2. Received an update on the Faculty's negotiations in connection with proposed regulations involving Nurse/Practitioners, Nurse/Midwives and Nurse/Anesthetists.

3. Declined to make a contribution to the Johns Hopkins Medical School Chapter of the American Medical Student Association for sending representatives of this group to its national meeting in Denver, CO

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4. Discussed the appropriateness of establishing an Ethics Committee or type of Judicial Council, but took no specific action. ☐

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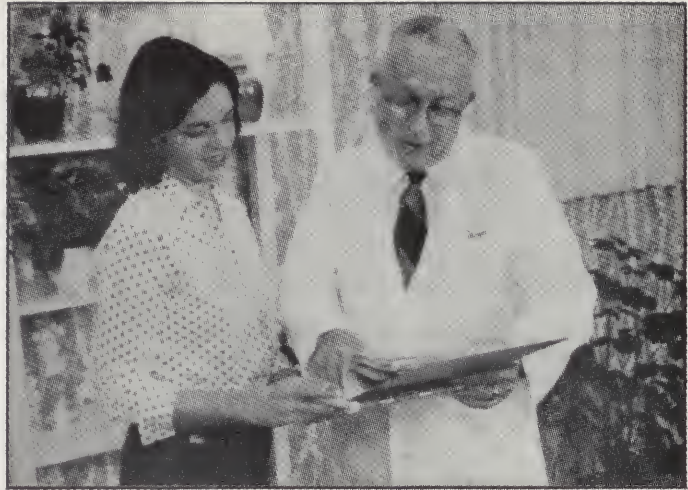

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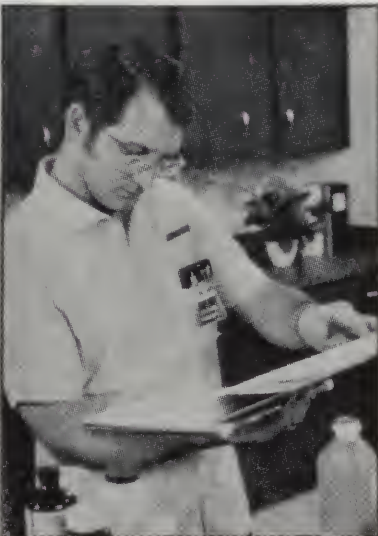
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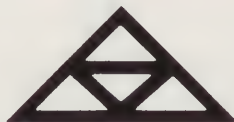
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Maryland Hospital Association Speaking of Hospitals

RICHARD J. DAVIDSON, Editor

Maryland Hospitals Second in the Nation in Controlling Inflation

Maryland hospitals are second in the nation (behind New York State) in the fight to control inflation of hospital costs, according to recently-released statistics from the Chicago-based American Hospital Association. In 1977, Maryland hospitals had the lowest rate of increase in hospital costs of the 50 states. Preliminary estimates indicate the trend will continue in 1979.

The 1977 statistics indicate that Maryland hospitals' expenses increased 9.27% compared with a nationwide average increase of 13.9%. This can be translated as a rise in expenses per patient day from \$171.47 in 1976 to \$187.36 in 1977.

Owing to the lower rise in costs in 1977, estimated savings to Marylanders were \$48 million in that year alone. That amount is in excess of \$130,000 savings per day. These savings occurred despite the fact that hospitals employed more people to care for patients in 1977 than in 1976.

In Maryland, expenses per adjusted inpatient day rose 9.27% right behind New York's 8.6%. The national rate of increase was 13.9%.

Richard J. Davidson, President of the Maryland Hospital Association, called the cost trend a dramatic one. "It is unmistakably clear that the citizens of Maryland are the beneficiaries of well-managed hospitals working cooperatively with the Maryland Health Services Cost Review Commission. We have some of the finest hospital managers in the nation running our institutions. We are also fortunate in having an effective and rational

form of payment regulation under the Commission. "In fact, I'd match Maryland's hospitals with those of any other state in the country for their ability to cope with the issue of rising costs."

"The credit for this progress," Davidson pointed out, "should clearly go to the trustees, medical staff and management of each of our hospitals."

In related comments concerning President Carter's recent anti-inflation message to the nation, Davidson called the cost record in Maryland so impressive that "Our state rate review commission and our hospitals' performance could match the goals of any Federal cost containment proposal now being promoted by the Carter Administration."

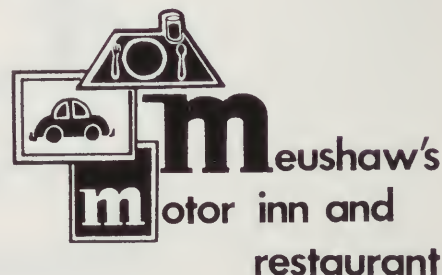
The Maryland Hospital Association is a statewide, voluntary association of 65 general and special hospitals organized for the purpose of improving hospital service in Maryland through programs of joint action, management efficiency, mutual assistance and cooperation. The Association is a private, nonprofit corporation supported by dues paid by its member institutions. □

Doctors Take Note:

The Maryland Academy of Family Physicians Annual Meeting and Scientific Assembly, 1979 will be held at the Bethesda Marriott Hotel in Bethesda, MD May 16-20, 1979. For details, contact Basil W. Holman, Academy Executive Director, at 1211 Cathedral St., Balto., MD or call him at (301) 539-6229.

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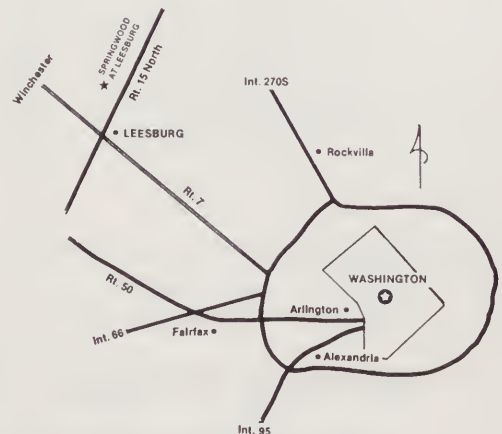
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Statistics and Surveys

In May, last year, I reported on the reactions of Faculty members to the Library, as indicated in the Faculty's annual survey of 20% of the total membership. Last year's survey had a single question regarding the success of the Library in assisting members in the private practice of medicine. My interpretation of that survey showed that 29% of the members felt that the Library served their needs well or satisfactorily. One per cent were dissatisfied, and 70% offered no opinion. Those who did not respond were placed in the "no opinion" category.

The 1979 survey's question about the Library was expanded to evoke more information. The intent was, first of all, to discern how aware members are of Library services and, secondly, to uncover the reasons that some members do not use the Library.

The Library portion of the questionnaire described the major Library services available to Med-Chi members and asked members to indicate their impressions of each service that they had used. The choices were: "very useful," "adequate" or "unsatisfactory." If members had not made use of the services, they were asked if this was because they were not aware of the Library's services, or for some other reason. Those who checked "other" were asked to comment or specify.

As was done last year, 1,000 questionnaires were sent to members; 294 have returned their questionnaires, 267 with answers to the questions regarding the Library; 208 respondents were aware of the Library and some

of its services; 129 of these had used the Library. Fifty-nine respondents were not aware of the existence of the Library and its services.

Considering just the respondents, we can say that 77.9% are aware of the Library, and 48.3% use it. However, it would be intellectually dishonest and statistically absurd for me to imply that these figures represent the entire membership. The questionnaires that were not returned (70.6%) and the 27 returned questionnaires that did not have answers about the Library make it impossible to apply the results to the total membership.

What then can be said regarding the results of the survey? At least 12.9% (129 out of 1,000) of those surveyed have used the Library. I know from our Library's records that, during 1978, 14.1% of the total Faculty membership called on the Library for assistance at least once. (This, by the way, represented an increase of 38.4% over the number of members who used the Library at least once in 1977.) The closeness of these two figures leads me to believe that most of the Med-Chi members who use the Library and received questionnaires filled out the questionnaires and returned them. If this is so, the impressions of this group (representative of about 20% of the Library's users) should be representative of all Library users. If so, then 14.7% of the Library's users think the Library is "excellent;" 61.7% think it is "very good;" 23.3% consider it "adequate" and .3% are dissatisfied with their contacts with the Library.

This is well and good, but what of the other 87.1% of the membership who evidently do not use the Library? The survey revealed many reasons for not using the Library. How much the comments of the 138 respondents who have not used the Library represent the reactions of the entire membership can only be conjectured. Still, the results are worth examining.

That five of the respondents were aware of the Library, but did not know how to use it, and 59 were totally unaware of it, is a puzzle. Every member received extensive publicity about the Library's services during 1978. Among mailings to every member was a new brochure that gives full details on how to obtain the services of the Faculty Library. In addition, talks by the Faculty Librarian and exhibits and talks by other staff members have emphasized the availability of these services throughout Maryland.

Thirty-one respondents stated that they use local medical libraries, possibly not realizing that the Faculty Library backs up most hospital libraries and that the Faculty Librarian is a consultant to many of them. Thus, these members benefit at least indirectly from the Library's services.

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to members of Med-Chi during the month of January, 1979:

1. Congenital toxoplasmosis in older children and adults	11	citations.
2. Hospital-based home health care	20	"
3. Standards for quality ambulatory care	34	"
4. Phenacetin abuse and its effect on the kidney	15	"
5. Diet restrictions for pancreatitis	6	"
6. Gardner's syndrome	30	"
7. Hypophosphatemia	41	"
8. Hypsarrhythmia	17	"
9. Medical aspects of the lightning-struck patient	6	"
10. Streptococcus mutans and endocarditis	6	"

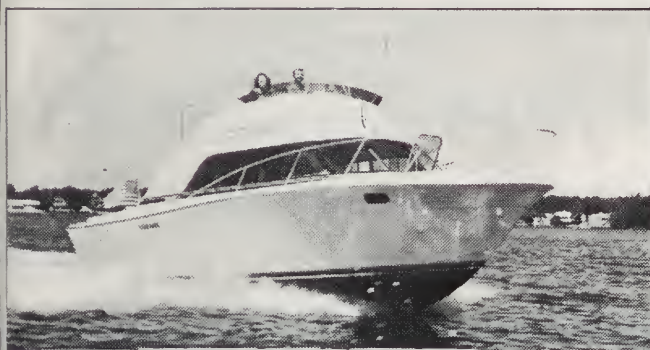
If you would like a copy of these searches or would like to have a search on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
Assistant Librarian

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42"70 Pacemaker MY, T/6V53's 56,500	34"77 Silverton Mainship FB diesel . . . 41,950	28"75 Silverton FB Sedan T/225's 18,500
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Twenty-seven respondents indicated that they never need to use a medical library; these probably represent most of those who did not respond to the survey, as well as the Faculty as a whole.

In answer to those who question the need for a Library because few members are engaged in research or writing papers, I would point out that the primary purpose of the Faculty Library is to help member physicians in their day-to-day practice. In 1978, the staff answered 8,879 requests from Faculty members. Very few of these were for members doing research or writing papers, and almost all came from practicing physicians and were related to the care of their patients.

The following are typical questions members have asked in the past month: "What is the effect of a respirator on the recordings of Swan-Ganz catheters?" "Send recent articles on acute surgical abdominal emergencies during pregnancy." "Want current information on clinical aspects and treatment of malignant thymoma." "Want a couple of recent articles on surgical intervention in, and medical management of, mitral valve prolapse." The Library receives 30-40 questions like this every day. While in no particular case can I say that a patient's care was changed because of information provided by the Library, I am convinced that some physicians provide better care as a result of their questions to the Library.

Most of you who have read this far are probably already Library users, many of whom have been lavish with praise, both in filling out the survey forms and in

talking with me. You can spread the word about the Library's services among your colleagues. When discussing a difficult or interesting case with other physicians, suggest that they call or write the Library for more information. When a question comes up at a hospital medical staff meeting, suggest asking the Faculty Library to find some information on the topic.

There is no practicing physician who would not benefit from at least one MEDLINE search each month, and an occasional photocopy of a journal article. Simply write or call in your question to the Faculty Library, or talk to the librarian at your hospital.

JOSEPH E. JENSEN
Librarian

Turn to page 32 for New Book Titles
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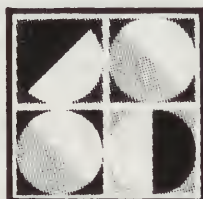
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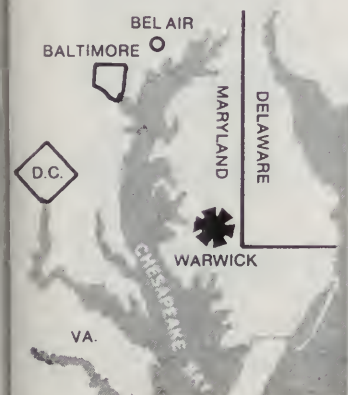


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New Book Titles

Cardiovascular Diseases

- WS National Heart, Lung and Blood Institute
290 **Cardiovascular Profile of 15,000 Children of School**
.N 277c **Age in Three Communities 1971-75.** Bethesda, 1978.
1978

Chromosomes, Human

- QS Zellweger, Hans
677 **Chromosomes of Man.** Lippincott, 1977.
.Z 51c
1977

Drugs

- QV Beyer, Karl-Heinz
55 **Discovery, Development and Delivery of New Drugs.**
.B 573d Spectrum Pub., 1978.
1978
QV Health Care Financing Administration. Medicaid Bureau
736 **Rx Guide to Drug Prices,** Wash., DC, 1978.
.H 434r
1978

Education, Medical, Undergraduate

- W Undergraduate Med. Educ. and the Elective System,
18 Duke Univ. Press, 1978.
.U 55
1978

Emergency Health Services

- WX Frazier, William H.
215 **Emergency Med. Technician Performance Evaluation,**
.F 848e Hyattsville, MD, Natl. Ctr. for Health Services Re-
1978 search, 1978.
WX National Center for Health Services Research
215 **Emergency Med. Services: Research Methodology,**
.N 277e Hyattsville, MD, 1977.
1977

Environmental Health

- WA Environmental Health; Quantitative Methods, Phila.,
30 PA, SIAM, 1977.
.E 61
1977

Gifts and Contributions

The Medical and Chirurgical Library gratefully acknowledges the receipt of the following gifts and contributions during December, 1978 and January, 1979:

Mrs. Harold Rosen.

A large library of psychiatric texts that includes many important first editions by Freud and Jung. These were collected by the late Harold Rosen, MD.

William B. Radcliffe, MD.

A group of bound periodicals.

Mrs. John H. Griffin.

A collection of medical and psychiatric texts, including several historical items from the collection of the late Olive Cushing Smith, MD.

Mrs. Paul Royse.

Twenty-nine medical texts from the collection of her late husband, Paul Royse, MD.

Samuel S. Glick, MD.

An autographed copy of **Huber, the Tuber**, by Harry A. Wilmer, MD. The book has cartoon illustrations to explain tuberculosis for the public.

Mrs. Joseph S. Blum.

A large collection of medical journals.

Forensic Medicine

- W Public Health Service. Health Services Administration
800 **Death Investigation: an Analysis of Laws and Policies**
.P 976d **of the US,** Rockville, MD, 1977.
1977

Heart Defects, Congenital

- WG Perloff, Joseph K.
220 **The Clinical Recognition of Congenital Heart Disease,**
.P 449c 2d ed. Saunders, 1978.
1978

Hypertension

- WG Krakoff, Lawrence R.
340 **The Renin System in the Diag. of Hypertension,** Hoe-
.K 89r chst-Roussel Pharmaceuticals, Inc., 1977.
1977

Immunology

- QW Turk, J.L.
504 **Immunology in Clinical Medicine,** 3rd ed. Appleton-
.T 939i Century-Crofts, 1978.
1978

Infant, Newborn

- WS Separation and Special-Care Baby Units, Phila., PA
420 Lippincott, 1978.
.S 479
1978

Legislation, Medical

- W Federation of State Medical Boards of the US, Inc.
40.1 **A Guide to the Essentials of a Modern Med. Practice**
.F 293g **Act,** Fort Worth, TX, Stafford-Lowden Co., 1977
1977

Occupational Diseases

- WA Plunkett, E.R.
400 **Occupational Diseases: a Syllabus of Signs and Symp-**
.P 737o **toms,** Stamford, CT, Barrett Book Co., 1977.
1977

Quality of Health Care

- W Donabedian, Avedis
84 **Needed Research in the Assessment and Monitoring of**
.D 674n **the Quality of Med. Care,** Hyattsville, MD, Natl. Ct
1978 for Health Services Research, 1978.

Religion and Medicine

- History
WZ Rosner, Fred
80.5 **Medicine in the Bible and the Talmud,** New York
.J3 KTAV Pub. House, Inc., Yeshiva Univ. Press, 1977
.R 822m
1977

Spinal Cord Diseases

- WL Hughes, John Trevor
400 **Pathology of the Spinal Cord,** Phila., PA, Saund-
.H 893p 1978.
1978



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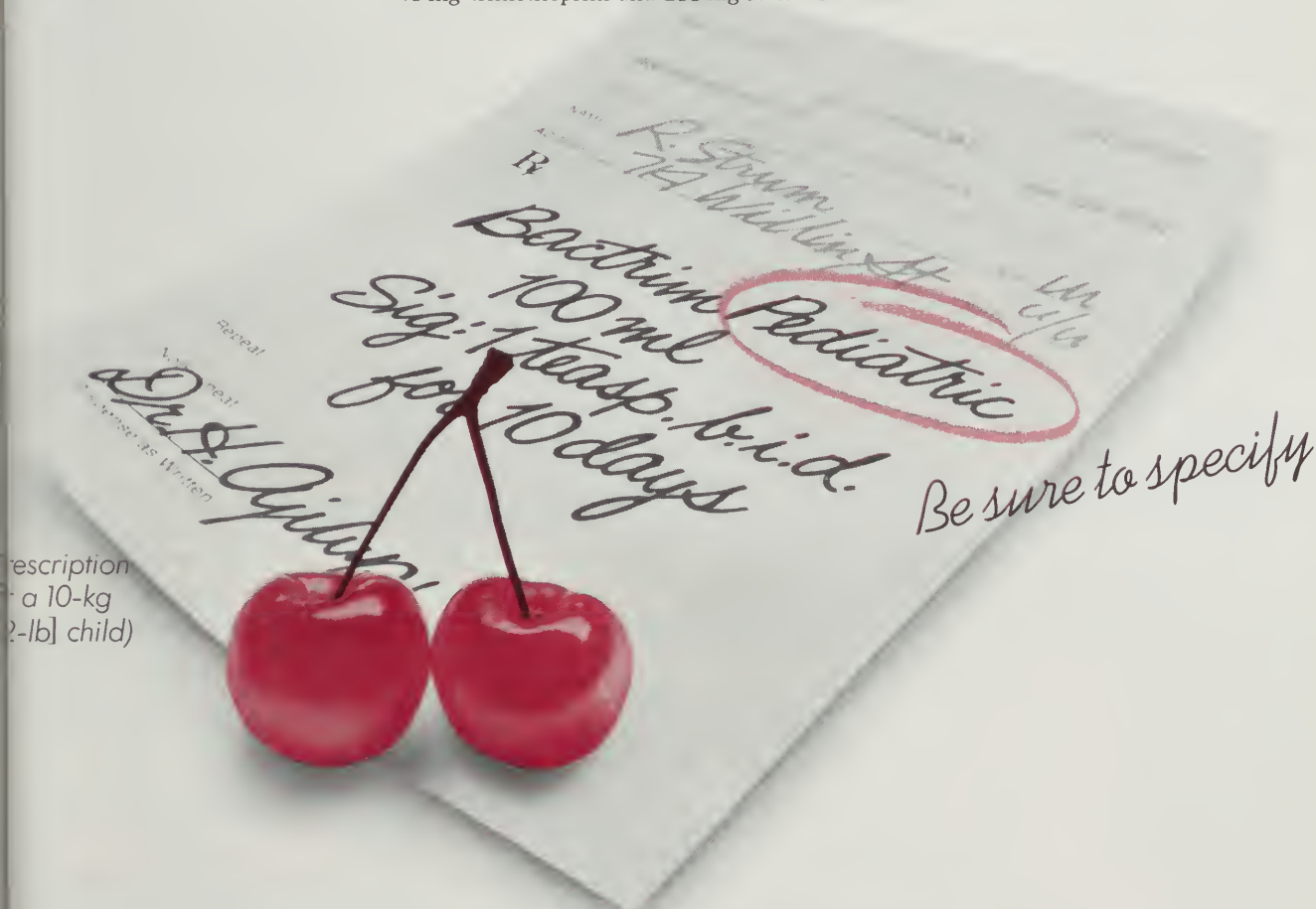
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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

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Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kg	Teaspoonfuls	Tablets
22	10	1 teasp. (5 ml)	½ tablet
44	20	2 teasp. (10 ml)	1 tablet
66	30	3 teasp. (15 ml)	1½ tablets
88	40	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

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Nutley, New Jersey 07110

April, 1979 Meetings

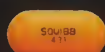
- April 4-7 Tennessee Medical Association
Airport Milton Inn
Memphis, Tennessee
- April 19-21 Alabama Medical Association
Birmingham Hyatt House, Civic Center
Birmingham, Alabama
- April 19-22 Missouri State Medical Association
Chase-Park Plaza Hotel
St. Louis, Missouri
- April 20-22 Georgia Medical Association
De Soto Hilton
Savannah, Georgia
- April 21-22 Iowa Medical Society
Hyatt House
Des Moines, Iowa
- April 22-25 Arkansas Medical Society
Little Rock Convention Center
Little Rock, Arkansas
- April 25-29 Arizona Medical Association
Safari Hotel
Scottsdale, Arizona
- April 26-29 South Carolina Medical Association
Myrtle Beach Hilton
Myrtle Beach, South Carolina
- April 29-May 2 Nebraska Medical Association
Holiday Inn
Kearney, Nebraska



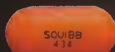
Conduct with Pronestyl® Tablets

Procainamide Hydrochloride Tablets

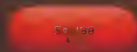
The only procainamide in
sugar-coated, easy-to-swallow tablets



250 mg



375 mg



500 mg

available in 3 tablet strengths for easier dosage
adjustment—up or down—in all patients
produced under exacting quality control standards
by Squibb—numerous critical control tests from starting
material to finished product
offered only under the Squibb label—your assurance
of reliable, quality therapy for life-threatening arrhythmias.

See following page for brief summary

PRONESTYL® TABLETS

Procainamide Hydrochloride Tablets

The prolonged administration of procainamide often leads to the development of a positive anti-nuclear antibody (ANA) test with or without symptoms of lupus erythematosus-like syndrome. If a positive ANA titer develops, the benefit/risk ratio related to continued procainamide therapy should be assessed. This may necessitate considerations of alternative anti-arrhythmic therapy.

DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of over-dosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been

reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Pronestyl Tablets (Procainamide Hydrochloride Tablets) providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride are available in bottles of 100 and Unimatic® single-dose packaging in cartons of 100. The 250 mg and 500 mg tablets are also available in bottles of 1000.



'The Priceless Ingredient of every product is the honor and integrity of its maker.'™

Should Med-Chi Members Also Be AMA Members?

By BLAINE TAYLOR

Interviews with Drs. Russell Fisher, Charles O'Donnell and Stephen Padussis to help you decide . . .

Contact Mr. Taylor, *Journal* Managing Editor, for reprint information and further data c/o the *Journal*, 1211 Cathedral Ave., Balto., MD 21201.

Introduction

The two symbols shown below are those of (left) the American Medical Association (AMA), founded in 1847 and (right) the Medical and Chirurgical Faculty of the State of Maryland (common-

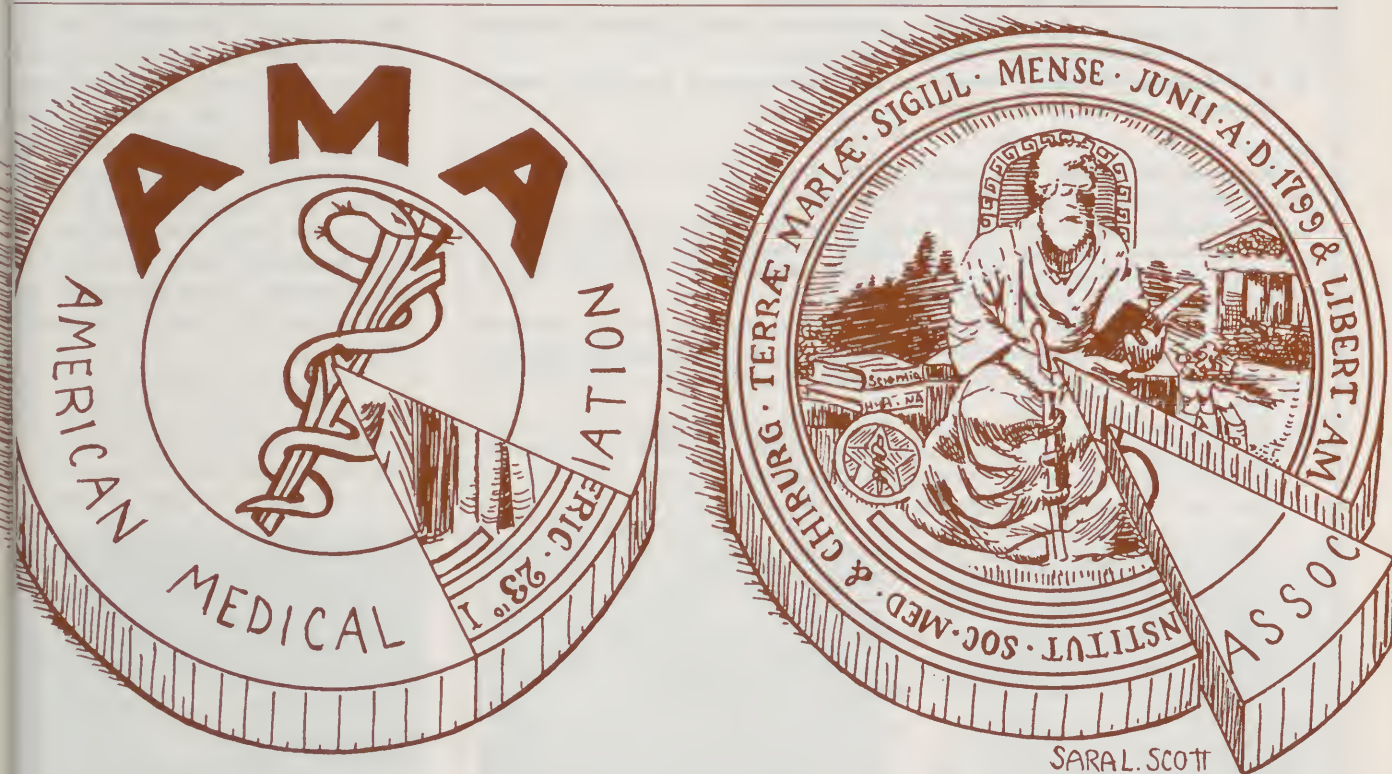
ly called Med-Chi, it is, in effect, the state medical society), begun even earlier, in 1799.

This year—as in every year past—the AMA is conducting a membership drive that it hopes will induce Med-Chi members not already belonging to the AMA to enlist.

Three prominent Maryland physicians (two of whom are past Faculty Presidents) who are members

of both organizations are Drs. Russell S. Fisher, 62; Charles F. O'Donnell, 61 and Stephen K. Padussis, 55. They are the Faculty's Delegates (Dr. Fisher is Senior Delegate) to the AMA's national House of Delegates, and they are all firmly behind the AMA's current "joint membership" campaign.

To further this effort, the three submitted to a lengthy collective



The seal of the American Medical Association shows the staff of Aesculapius enclosed in a circle. The staff of Aesculapius is a single serpent twining around a wooden staff. The serpent symbolism is of Greek origin. The serpent was an important part of the cult of Aesculapius' Greek temples. The serpent's relationship to healing has been attributed to its keen sight and long life, and to the fact that it annually renews its skin, suggesting rejuvenation and renewal of youth and health. Around the outside of the circle are the letters "AMA" and the words "American Medical Association." The seal of the Medical and Chirurgical Faculty of the State of Maryland, a fourth revision of the original Faculty seal, shows the Greek god of medicine, Aesculapius, seated, holding his staff, the traditional serpent, and surrounded by medical textbooks whose titles suggest the basic sciences which form the basis for medical knowledge. The myths regarding Aesculapius may have developed around a historical personage, perhaps an actual person. The term "Aesculapius" is sometimes used to mean any practitioner of medicine. Homer describes Aesculapius as "a mortal." In mythology, Aesculapius was the son of Apollo and Coronis. According to both Homer and mythology, Aesculapius learned medicine from Chiron, the Centaur. The Faculty seal shows a Greek temple of healing, realistically situated on a wooded slope. Such temples were centers of medical knowledge and a cult of healing. Individuals would spend the night sleeping in such a temple as part of their therapy. The Greek words at the bottom of the seal are taken from Homer's *Iliad*. A literal translation of the three words is, "Of more importance than other men." When put into the context of the surrounding lines in Homer's *Iliad*, a proper translation would be, "A physician is more important than other men, because he can attend wounds and still pain." Latin words surrounding the seal read, "Medical and Chirurgical Society of Maryland, Seal, Month of June, the 1799th year of the Lord and the 23rd year since the establishment of American liberty."—Joseph E. Jensen, Faculty Librarian.

Table 1: AMA Membership Benefits

AMA membership provides physicians with a broad range of tangible benefits both professional and personal. Among them are:

1. **PUBLICATIONS: Journal of the American Medical Association (JAMA)**—To help physicians keep on top of the latest scientific developments every week. **American Medical News**—Provides the latest information on events and personalities affecting the practice of medicine. **Specialty Journals**—For specific scientific information in a specialty, physicians have a choice of one of nine specialty journals.
2. **MEMBERS INSURANCE PROGRAMS:** AMA insurance programs provide substantial coverage at a cost considerably lower than what a physician would have to pay on an individual basis. The programs available are: Group Life Insurance, Excess Major Medical, Disability Income Insurance, Supplemental "In-Hospital" Insurance, Accidental Death and Dismemberment Plan and Office Overhead Expense Insurance.
3. **SEMINARS: Negotiations**—Designed to help physicians develop and improve their negotiating skills. **Practice Management**—Provides proven guidelines for effective and productive management of the physician's practice. Includes physical plant, personnel, procedures and patient relations. **Speakers' Training**—Instructs physicians in the methods and techniques of effective public speaking.
4. The nation's largest **Physician Placement Service**.
5. **CME programs**—expanded and regionalized to make Continuing Medical Education more convenient and less expensive.
6. The **research resources** of one of the nation's most up-to-date medical libraries.

An important benefit of membership are AMA's efforts to represent physicians and the medical profession in Washington:

7. **INTERESTS:** One of the AMA's major functions is to act as the advocate for physicians' rights and for the quality of patient care. Effective representation is critical because of the Federal government's mounting pressure for tighter regulation and control of medicine.
8. Every year, the AMA monitors, analyzes and reports on thousands of pieces of health-related legislation and regulations—at both the Federal and State levels. To meet specific legislative needs, the AMA has drafted its own bills.
9. AMA officers and trustees frequently testify before Congressional committees and Federal agencies. During the 95th Congress, the AMA has submitted formal, written testimony or furnished witnesses to testify more than 200 times on bills and regulations affecting health care delivery, and, on several occasions, it has been necessary for the AMA to take the government to court. In fact, the AMA spent over \$1,000,000 in 1978 on legal fees to defend the rights of physicians and patients.
10. **AMA Members' Retirement Fund.**
11. Young physician **"Starting Your Practice"** management workshops.
12. **Training programs for your medical office personnel, You, the Telephone Manager and Medical Collection Management.**

Here are examples of the AMA representing physicians' interests before Congress and governmental agencies:

13. The AMA is challenging an FTC administrative judge's initial decision that the AMA cannot establish ethical guidelines on physician advertising and solicitation.
14. The AMA is defending three antitrust suits filed by chiropractors to preserve medicine's First Amendment rights to speak out on public health issues concerning physicians.
15. The AMA worked with hospital groups to defeat the Carter Administration's proposal for rigid cost controls on hospitals which would have adversely affected the quality of hospital care.

The AMA is also involved in projects to improve rural, inner city, jail and emergency care; encourage family practice in medicine and curtail TV violence. There is also the Auxiliary's campaign to promote adequate immunization among the millions of our youngsters.

(All Tables courtesy of the AMA.)

interview held at the **Journal** office at the Faculty's headquarters building at 1211 Cathedral St. in downtown Baltimore late last year.

Dr. Fisher

The freewheeling, tripartite interview on Med-Chi and the AMA began, appropriately, with former Faculty President Dr. Fisher. The taped results follow.

Medical Education

Dr. Fisher, define, please, your role within the AMA.

I'm the Senior Delegate from Maryland, a post I've held for about the last five-six years; I've been a Delegate for 15 years within the structure of the AMA itself. I was elected six years ago by its House of Delegates to the Council on Medical Education, and re-elected in 1977; I'm now its Chairman, also. These activities concern education at the undergraduate level, the approval of accreditation of the medical schools, the accreditation of the postgraduate residency programs, which are now handled by a committee structure and, to a lesser extent, the burgeoning area of Continuing Medical Education (CME.)

The AMA started in medical education with a council as far back as 1904. Its primary role at this time is all three areas of medical education, as I've indicated. In undergraduate medical education, it is conjointly with the Association of American Medical Colleges—it being a 12-member committee, run half and half by the two parents—which are charged with the periodic reexamination of all medical school facilities, curricula and everything else having to do with the process.

It makes recommendations for improvement where indicated and for accreditation of the school if the program is satisfactory. This operation is very vital to the whole process of medical education in the United States. Without some sort of uniformity and quality control guaranteed by the Committee there's no telling what might have happened!

Until the famous Simon Flexner Report of 1910, there was all kind of incompetent and inadequate

curricula in medical schools, which were turning out people who were simply unsafe. Under the pressure brought about by the Flexner Report within the AMA, this situation was cleared up and, since the early 1920s there've been no more 'Class B' medical schools in this country, although there's still a lot of them around the world.

One can no longer be licensed in the US unless he has graduated from an accredited medical school, where he's following the regular American medical educational process.

As far as the graduate medical education process is concerned, the ultimate approval of the standardization of the residency review process has now been given over to a liaison committee, which in membership consists of the AMA, the American Association of Medical Colleges, the Council on Medical Specialty Societies, the American Board of Medical Specialties and the American Hospital Association. These groups are involved in a process that was strictly American medical until five years ago when the Liaison Committee on Graduate Medical Education was formed, but the process still is staffed by the AMA, and the AMA pays more than half the costs of its total financial operation, which, curiously enough, has a budget—just for

graduate medical education—of \$1,800,000 per year. All of this is spent on making the educational process available to residents and trainees as they advance their training from medical school to a sufficiently mature knowledge that enables them to be fairly-safe practitioners of medicine.

The AMA has an advisory committee in each of the three areas of medical education, which does a lot of the preliminary review of programs. We have an additional conjoint committee that's concerned with the accreditation of programs in medical technology, respiratory therapy, X-ray technology, etc: all together, some 15 of the allied medical health professions submit for accreditation their educational programs to what was formerly the AMA's committee on allied health and professional education, now called CAHEA—Committee on Allied Health Education Accreditation.

There was a void, a need for quality control, and the AMA was the only national body that could assume this responsibility. Early on, the profession responded to the obvious need and spent a large portion of its budget on the educational process. Anybody who goes to medical school or does a residency or gets continuing education depends upon the AMA for its

quality; therefore, local people—all doctors—who're concerned with this process ought to support the AMA's activities in these fields, if for no other reason than that it's a moral debt which we all owe because all of us enjoyed it.

We've all fed at the fountain for years and years, and continue to do so.

It's ludicrous for our colleagues who haven't chosen to enjoy the AMA to sit back and enjoy the fruits of their fellow men who pay the bills that operate the system.

Reasons for Non-Membership

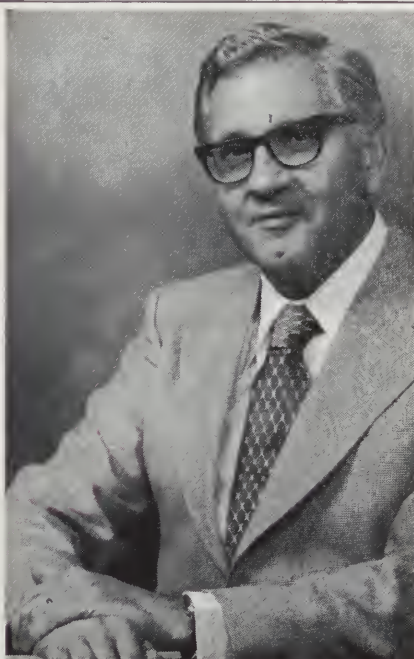
It is possible that many younger physicians—say in the age bracket of 35-45—think the AMA is too conservative, and perhaps don't want to join for that reason or just aren't "joiners" or interested in organized medicine?

There're a number of reasons. One is that, as you say, a number of our colleagues aren't "joiners." They don't want to have anything to do with anything that smacks of politics. They prefer not to have any connection with what is, in many ways, a political organization.

The second important group is that which is just plain too stingy to put out the money that membership in the county and state societies and AMA means. It isn't an



DR. FISHER



DR. PADUSSIS



DR. O'DONNELL

insignificant amount! You have to belong to the local and state societies before you can be in the AMA. Each has an identifiable set of dues with an identifiable objective. (See Table 2—ed. note.)

Can someone be an AMA member and NOT a member of the local groups?

Only if they're in the Armed Forces or in Veterans Hospitals or some other governmental services. Another reason younger physicians

don't join is that they're starting out in practice, and that amount of money is really meaningful to them. Recently, the AMA has adopted a policy of permitting newly-established physicians to join at half the annual dues for their first year in practice. Unfortunately, there are also those content to ride on other people's coattails. That's true of any organization, though.

A certain number of people are inherently extremely liberal and

against the AMA's relative conservatism; they literally dislike what the AMA is doing, and therefore won't join. People who're completely convinced that nationalization of health under a socialistic scheme is the way to go obviously aren't going to spend their money in dues to the AMA, when the AMA is taking a more conservative course, which is that the majority of our members certainly believe in the free practice of medicine.

ARE there any doctors who're actually ADVOCATING nationalization?

Oh, yes.

Are these people those who might be hired later as NHI administrators?

No, I really think there're some beknighted people who're sufficiently socialistic in their views in that they regard the division of the wealth without relation to the division of the effort to be the millennium at which we should someday arrive. The majority of them, I think, are in the younger age group, though.

Academic Non-Members

Are the majority of doctors in Maryland who're NOT Med-Chi/AMA members centered in academic medicine, such as at the Hopkins and University of Maryland Schools of Medicine?

Among the areas that're conspicuous for low membership, the centers of academia are obvious.

Is that because these people are transient and feel that they're only here for a couple of years, only to move on later to some other teaching position, so why SHOULD they join?

I'm not concerned with Residents, or even those who complete Residencies here, but the academic people feel they're doing their own bit in the educational process and so say "Let somebody else do the rest of it." They're not interested in affiliating with an organization involved in politics, as the AMA is, but political involvement is dealing with the malpractice issue, getting legislation that protects the patient, helping control infectious, contagious disease, etc. I feel they, too, have a stake in joining.

Table 2: Dues

1. **Local, component society dues vary;** check your individual society
2. **State (Med-Chi) dues are:** \$160 a year (figure includes \$5 for the Society's Educational Fund) for members in their third and subsequent years of practice, members in their second year of practice pay \$90, while those in their initial year pay \$80
3. **AMA dues (in addition to those figures cited above) are:** \$125 annually for those in their first year of practice, and \$250 a year thereafter

Table 3: What Did Not Happen Because of the AMA

1. **National Relicensure.**
2. **Regulation** of residency assignments and rationing by specialty.
3. **Cradle-to-grave, Federally-run National Health Insurance**
4. **Capricious** utilization review regulations
5. **Precertification** of Hospital Admissions
6. **Full "public utility" control** of medicine
7. **Phase V controls on MD fees**
8. **Federal (or state) licensure** of physicians' office laboratory
9. **Legislation imposing** additional restrictive medicare reimbursement levels on physicians

Table 4: What Did Happen Because of the AMA

1. **Improvement of the Keogh Law** to permit increased annual contributions for retirement to 15% of earned income or \$7,500, whichever is less—A savings worth many times the annual dues
2. More than 4,000 Continuing Medical Education programs accredited for benefit of the profession
3. AMA developed guidelines for **improving medical and health care in jails** now being tested in 30 communities
4. **Financially hard-pressed medical and dental schools** in District of Columbia receiving Federal support
5. Universal health insurance claim form—more than nine million already in use
6. **Enactment of the Military Medical Practice Act** that makes the Federal government exclusively liable for malpractice damages in the military and uniformed services
7. Detailed AMA policy on **Hospital-Physician** relations designed to protect the rights of medical staffs and individual physicians
8. **AHA acceptance of concept** that medical staffs should be represented on hospital boards
9. **Rapid expansion of medical schools** in past decade
10. **Extensive Health Manpower Training** support.
11. **Development of legislation** for emergency medical services systems
12. **Significantly increased pay** for military, VA and other Federal physicians

Other Groups

All right. Is the AMA the only nationally-recognized group of and for physicians?

No. It has no serious rivals, but there is also the black National Medical Association (NMA). We have a generally cooperative operation with them, as we invite their officers to participate in our deliberations at the Annual Meetings, and vice versa. There is no open rivalry. They're organized to do something about what they consider to be the poor participation of blacks in American medicine.

Delegate-Society Ratio

Earlier, in private, you mentioned to me that, if more Med-Chi members joined the AMA, Med-Chi would be entitled to a FOURTH Delegate. Is the ratio based on one member per every so many physicians? How does the formula work?

One Delegate is the base for any state, and then you get an additional Delegate for every 1,000 members or any portion. The term of office for each Delegate is three years.

US and Foreign MDs

Do you think it's fair to say that US doctors are the best-trained in the world?

No question about it! There're other systems that're probably comparable, such as the West German educational process.

What about Soviet doctors, and those in Iron Curtain countries in Eastern Europe?

From people I know who've gotten sick there, their facilities are incredibly inadequate.

FMGs in the US

Who deals with the issue of the Foreign Medical Graduates? From what many people tell me, there're a lot of them practicing medicine here who cannot speak the English language. One suspects that the nurses are really practicing medicine and teaching the doctors as they come in.

The AMA is one of the many agencies concerned with this problem. They helped establish the Educational Council for Foreign Medical Graduates to participate in

writing a series of regulations requiring minimal English and educational proficiency in ethics, as well as technical areas.

There's a point of view that Americans share—which I consider a general understanding—which isn't characteristic of medicine all over the world in the less fortunate countries, where some patients are treated more like animals than people. Early on, the AMA stated in all the FMG residency requirements that special training in the understanding of the humanistic aspects of medicine was necessary.

More recently, the State Department, in response to pressures from the AMA and the American Hospital Association, has changed the

rules through which FMGs get into the US. Now, instead of coming in with a special visa that declared doctors were in short supply and therefore didn't have to be limited by quotas, all FMGs who intend to come in are limited by Immigration quota.

What about in terms of time spent residing here?

The Immigration group constitutes the bulk of the better than 6,000 doctors entering this country every year. In addition, the State Department had a great plan 20 years ago under which we'd have exchange visitors—citizens of other lands who would come here, learn how to practice medicine, do a residency and then go home. Unfortun-

Table 5: AMA National Health Insurance Bill

1. **Builds on the present system**
2. **Provides Federal assistance on basis of need**; the most help goes to those who need it most
3. **Allows everyone to choose his own physician, dentist, health insurance plan and type of practice arrangement**
4. **Provides more comprehensive benefits** than any other bill and includes coverage against costs of mental illness
5. **Protects against costs of catastrophic illness** without any ceiling on benefits
6. **Provides realistic preventive care benefits** including well-baby care, physical exams, immunization, out-patient psychiatric care and X-ray and lab work
7. **Provides continuation of coverage for the unemployed**
8. **Provides supplemental coverage for non-employed medicare enrollees**, bringing their benefits up to NHI level
9. **Cost Control by limiting Federal help** to those in need, co-insurance (except for the poor), competition among carriers and providers, many services on ambulatory basis to avoid hospitalization
10. **Least Expensive of all NHI bills** in new Federal spending.

Table 6: AMA Statement on National Health Insurance

The AMA believes that everyone should have health insurance, at adequate benefit levels, and that the gaps in the present system that affect some segments of the population need to be filled. Nearly 190 million individuals have private or "public" insurance coverage, and the benefits provided under much of the coverage are broad and comprehensive. Approximately 20 million people do not have access to coverage for varying reasons, and the Association supports the extension of appropriate insurance coverage to these segments of the population.

The Association is cognizant of the growing problems facing other nations with government-controlled health programs; the rising costs of health care and the effect that a massive Federal program would have on an already-overheated segment of the economy and the priority that the nation needs to give to controlling inflation and eliminating waste and inefficiency.

The Board of Trustees, the Council on Legislation and the Council on Medical Service will be conducting a comprehensive review of National Health Insurance policy over the next several months. A complete summary report on this issue and any recommendations that might be appropriate will be submitted to the House of Delegates in ample time for consideration by the Delegates prior to the 1979 Annual Meeting in July or a special meeting of the House if it becomes necessary for one to be held.

nately, this bombed, because they got here, saw how good it was—not just financially, but also in terms of facilities and capabilities to practice medicine as opposed to the poor conditions at home—and they stayed. They married an American or had a child here or petitioned the State Department to void the original contract, which said they would return home after two years, but that was extended eventually to five years to complete a residency. Then they said, “You may come back after you’ve been home for two years,” but anybody could come back as an immigrant. They got special priority because they were doctors, but the State and Labor Departments abolished that. Also, the rules under which you could come as an exchange visitor were tightened up.

Now, if you come as an exchange visitor, you need a letter from your government stating it’s sponsoring you, and that your country needs the kind of education we’re going to supply. Furthermore, you’re committed to go back in two years. You must have a letter from the organization that is going to train you stating it has the facilities and

is willing to train you. You must pass a special examination which is equivalent of parts one and two of the National Board of Medical Examiners, too.

I’d like you to respond to this fictional scenario: first, doctors in the US are under the gun from the Federal government to fill medical slots in hospitals, and there aren’t enough doctors to go around; second, there’s a nefarious plot to keep Americans OUT of medical schools because eventually they would earn more money than FMGs and thus cut into the profits US doctors get; third, the method by which the Federal government is gotten off the backs of the profession, fills the slots and keeps Americans out of medical schools is to staff the hospitals with FMGs. Is there any truth in that at all?

There was never any plot to limit medical graduates in the US. On the other hand, over the last 20 years, to my knowledge, there’s been a strong and continuing effort to increase the numbers of American graduates.

In the middle 1960s, we graduated 7,000 students a year na-

tionally from 70 schools. With the strong support of the AMA Council on Undergraduate Medical Education, we now have 116 medical schools—with 125 to exist within the next three years—graduating 15,750 people, annually. The output has more than doubled.

How come we have Americans going abroad to study medicine?

Medicine has been such a revered and lucrative profession that it’s very attractive. For many years, when engineers were in surplus supply, bright students turned to medicine so that there were three or four candidates for every vacancy in a medical school’s freshman year. Now, in relationship to the number of slots available, that number has decreased, within the last five years.

Postgraduate Education

A recent article in the Baltimore SUN about medical students stated what THEY felt about being in medical school. The overwhelming feeling they had was that there just wasn’t enough time to absorb all the material. One person talked about opening a book, merely looking at the subject and then going on. Another said that in every class he went to, he was assigned a hundred pages daily to read. Part of the reason for that regimen, of course, is to discipline the person to cram a great amount of activity into a small amount of time, but is that really very wise—especially in an area like surgery?

Well, this is the reason that specialization developed in the first place. There was an ever-increasing, detailed body of knowledge. Take a hand surgeon, for example. Even though I’m something of an anatomist and oncologist, I would be totally lost if I had to reset in detail a hand injury to take care of the necessary safeguarding of nerves and blood vessels, etc. It takes a person literally years to learn to deal with the intricacies of the anatomy that God gave us in the most productive, protective way. All you can do in medical school is to give them a smattering of information about the certain state of the art and science, and

Table 7: AMA Efforts for the Public

AMA has sponsored bills to:

1. **Develop** model rural health delivery systems
2. **Improve** Indian health
3. **Create** more equitable way for blood banks to acquire blood
4. **Require** adequate prescription drug labeling; legislation based on AMA bill to develop community emergency medical programs passed 93rd Congress. (Public Law 93-154)

AMA has also supported:

1. **Drug Abuse Education Act**
2. **Efforts to ensure safe, quality medical devices**
3. **Maximum funding** for maternal and child health
4. **Federal assistance** for schools and students of medicine, nursing, public health
5. **Adequate appropriations** for NIH research and for FDA
6. **Strong clean-air standards**
7. **Noise-abatement** legislation
8. **Migrant health care program**
9. **National Health Service corps program to supply physicians for shortage areas**
10. **Research and control of communicable disease and VD**
11. **Federal support** for community mental health centers
12. **Radiation safety laws**
13. **Research** on kidney disease, cancer
14. **Control** of lead-based paint

hope that they can see in their post-graduate years areas that interest them in which they will keep up. That's a continuing struggle. I don't envy the family practitioner who has to cover the waterfront, because the task is incredibly great, and he's under all the other pressures of a busy practice, too!

Thank you, Dr. Fisher. Now, we'll turn to Dr. O'Donnell.

Dr. O'Donnell

Charles F. O'Donnell, MD, lives and practices at the same address on York Rd. in Towson, MD. Both his practice and his involvement in organized medicine began in 1945, when he joined the Baltimore County Medical Association (becoming its President in 1952), the AMA and Med-Chi (he was Faculty President-Elect in 1961-62 and President the following year.)

Born March 26, 1917 in Brooklyn, NY, his elementary education took place at a public school in Malverne, Long Island, but he did not attend high school; instead, he took the New York State Board of Regents Examination "In enough subjects," he says "to piece together a college entrance diploma."

In 1941, upon entering the University of Maryland School of Medicine after having completed the necessary educational requirements in Chemical Engineering at the Johns Hopkins University, O'Donnell went to work at the Bethlehem Steel-Fairfield Shipyard Hospital. He received his MD degree in 1944, the same year he was honorably discharged from a Reserve Commission of three years in the US Navy Medical Corps.

Following an Internship at Baltimore's Mercy Hospital, he was appointed an Assistant Surgical Resident in January, 1945; and began practice of Family Medicine in Towson.

Dr. O'Donnell has been a member of the Maryland Academy of Family Practice since 1948 (and was its President during 1948-50), was a Founding Member of the American Academy of Family Practice (in 1947), and was a Delegate from the state to the National Academy during 1949-55.

AMA Activities

Since Dr. O'Donnell has been heavily-involved with the inner workings of the AMA for the last 15 years as both a Delegate and Alternate, he naturally feels that seniority and experience in the two jobs are important, and the Journal interview with him began on this note.

•

I agree with Dr. Fisher that the AMA system is so complicated that you have to spend years and years learning it in order to contribute maximally. That's why I think that the experienced representation Med-Chi enjoys with the AMA should be retained.

It's difficult for younger physicians who're just starting out in their practices to be heavily-involved in this manner with the AMA, because they just don't have the time for it. Make no mistake about it—being a Delegate to the AMA is very financially costly, too. While the expenses of the Delegates and Alternate Delegates are almost covered for our trips on

AMA business, we all lose income when we're away from our practices.

I'd be willing to bet that any physician who serves as a county medical society President has his income decreased by 10% the year that he serves as President, and a Faculty President loses 20%.

Why do you do it?

Because it's what I believe in, and I can afford the income-loss now that my family is raised. I feel that, if you're part of an organization, you should participate fully. Getting back to the youth question, you have to start a prospective Delegate out rather young because it takes about 15 years of experience to build up the knowledge you need to get the job done when you reach Delegate. My route over the years was a little different from Dr. Fisher's. I went from almost every committee that the county medical society had to the state society and worked on almost every committee it had, then was an Alternate Delegate for nine years, attending meetings to famil-

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iarize myself with the operation and, finally, have been a full Delegate for the last seven.

I'm on the AMA Council on Long-Range Planning, and was recently elected to the President's Forum, which is the Committee selected to get together the program for the state Presidents yearly at the AMA meeting.

Concerning the Council on Long-Range Planning, would it be fair to say that the decisions you're making now will affect American medicine—and, ultimately, everyone—well into the decades of the Eighties and Nineties and possibly into the next century?

I think so. First, let me say it's an appointment I'm proud of, since it's one of only two made by the Speaker of the AMA House of Delegates to represent the House, which is the AMA ruling body. The membership of the Council is unique among AMA councils in that it's fully appointive. Aside from the two Delegates appointed by the Speaker, two people from the membership-at-large are also appointed and one member from the AMA resident membership, too. The Chairman of the Board of Trustees of the AMA appoints two members from the Board, two from the AMA membership-at-large and one from the medical student membership.

By being appointed, we don't have to be afraid of saying things that are unpalatable.

How long is your term of office?

Three years, and we can be reappointed for three consecutive terms for a total of nine years.

While we answer to the Speaker alone, he answers to the whole House, and must stand for reelection, so he'd better not appoint somebody opposed by the House; he'll be in hot water if he does!

Thus, I feel that my appointment has House approval tantamount to election.

The Council's Work

Describe for our readers, please, the Council's work.

Basically, the Council's function is to study and make recommendations on the long-range objectives of the Association in terms of research, organization and programs. It also serves as a focal point for the planning activity of the Association to stimulate and evaluate planning throughout the organization. We study the future environment in which medicine and the Association will function, plus collect relevant data to be interpreted, transmitted and studied for the Board of Trustees for distribution to the decision-makers throughout the Association.

From time to time, on an annual basis, the Council issues reports to the House of Delegates.

Group vs. Solo Practitioners

One of the things we're working on is group practice and, strangely enough, there are more AMA members in groups than there are in solo practices, which makes me feel that one of the reasons we lack membership in the AMA is that no one is selling the AMA to the individual solo practitioner, whereas, in group practice, 90% of the men

in the groups belong. Many specialty societies encourage their members to belong to the AMA, while no one encourages the solo person.

There are some 880 different methods by which the AMA gets dues from its members. Due to the fact that we're a federation, we can't bill everyone. If we, in some way, could bill directly every physician in America, instead of through the county and state medical associations, we'd have a much better membership.

Why can't you?

Because the states have that right as a federation; you have to belong to the state society first.

Female Representation

The Council also works on the role of female physicians in organized medicine. Today, women feel that they should have a greater role than in the past. It's very hard to "slot" positions on the AMA Council for women. We do slot them for medical students and interns and residents, but they're only there for a period of a few years. We're encouraging the AMA Trustees to appoint women to committees where possible. We do have a woman on the Council and, this past year, 25% of all medical school graduates were women, and it's going up every year. Eventually, the mere fact of these increasing numbers will take care of their having a fair say in everything if they actively participate. Twenty years from now, one-third of all practicing physicians will be women.

Another item that the Council is

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examining is the role of the AMA itself—what **should** it be doing? At times, the Council acts as a sort of “think tank” to consider all kinds of problems, and we see this happening all the time in the House, too.

Financial Work

Beginning in December, 1974, I began serving on a Special Ad Hoc Committee when the AMA was just about bankrupt. We met on the average of one week a month over the next six months, sometimes five days at a stretch. By June, 1975, the Committee came up with a Special Committee Report which helped turn around the finances of the AMA. That was when we more than doubled the dues, made plans to get rid of all unprofitable journals and suggested selling certain pieces of land. Over the last three years, we've gone from practically no cash reserve—plus a million dollars' worth of property and a debt note of \$3 million—to about \$38 million in cash reserve to offset an IRS bill of \$15-30 million on back taxes we must pay if we lose our court fight. I think that Special Committee did a pretty good job!

Other AMA Activities

If there had never developed the threat of socialized medicine, would there be a **NEED** for the AMA?

Yes. The AMA spends less than three percent of its annual budget on so-called “political” activity. The AMA produces **JAMA** and other journals, all sorts of pamphlets for the public, spends money for medical education, provides its share of the costs of the Joint Commission for the Accreditation of Hospitals (JCAH), does govern-

ment work under contract on health and maintains the largest, single, factual health library in the world in Washington.

As far as socialized medicine is concerned, I think we're farther from it today than we've **ever** been, because the public doesn't want it. We may eventually have a **form** of National Health Insurance (NHI), but it will be modified so that we, as physicians, will have input into it. It won't be something that terrifies us all: “You live in Zone 10; you see Dr. Number 275.” I recently took a trip to visit the Canadian health system to study it. This is another reason for physicians to join the AMA! Canada wouldn't be where it is if the profession there hadn't been fragmented.

Is there anything you'd like to add?

Since I keep pretty close to the pulse of things in my community at home, I think I have a broad knowledge to give to my AMA work. From my position within the home county and state medical societies, I hear how various groups react to different things.

I cannot stress too strongly that we should find some method whereby every physician in America should be invited to join the AMA.

Thank you, Dr. O'Donnell.

Dr. Padussis

The third member of the Faculty/AMA troika, Stephen K. Padussis, MD, of Lutherville, MD was born May 5, 1923 at McKeesport, PA, son of Constantine Gus Padussis and Anna L. Padussis, the youngest of four children.

The family moved to Baltimore

when Stephen was three years of age. He was educated in the Baltimore City Elementary Schools and attended Baltimore City College from 1939-42. He did his undergraduate college work at the University of Maryland from 1942-44 and matriculated at the University of Maryland Medical School in July, 1944, graduating in May, 1948 with an MD degree. (He was also certified in postgraduate surgical anatomy work there.)

His internship was in St. Agnes Hospital from 1948-49, where his Surgical Residency was served from July 19, 1949-June 30, 1953. Dr. Padussis then entered the practice of General Surgery at 3301 N. Charles St. in Baltimore in association with Dr. George Stewart from 1953-54. In 1954, he was called into active service with the US Army 43rd Mobile Army Surgical Hospital (MASH) in Korea through 1956. He returned to the private practice of General Surgery that year and had his office at 401-402 Medical Arts Building until 1969, when Dr. Padussis transferred his surgical practice to the St. Agnes Medical Center at Pine Height and Wilkens Avenues, where he is currently practicing.

His professional memberships include the Baltimore City Medical Society (1953-present); the Baltimore County Medical Association (1978), Med-Chi (1953-present), the AMA (1953-present), AMA Delegate (1977-present), the American College of Abdominal Surgeons (1962-present), the Southern Medical Association (1956-present) and the American Geriatrics Society (1958-present).

Dr. Padussis' hospital appoint-



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His civic activities have been the following: appointment in 1962 by then-Gov. J. Millard Tawes to the Chesapeake Affairs Commission, the Maryland State Physical Fitness Commission (1962-71), the Baltimore County Board of Health (1969-74), being a Board Member of the National Conference of Christians and Jews, the Malpractice Task Force, Chairman of the Professional Component of the United Fund of Central Maryland (1978), appointment by then-Gov. Marvin Mandel to the Planning Advisory Council of the Comprehensive Health Planning Agency, appointment to the Governor's Commission to study Nursing Homes and the State's Health Coordinating Council (1974-present.)

A member of the Baltimore PSRO Committee on Institutional Care since 1977, Dr. Padussis' Med-Chi involvement has included Chairmanship of its Legislative Committee (1972-74 and 1978-79) and being on its Liaison Committee on Nursing Homes (1973-75.)

Dr. Padussis received the Governor's Citation Award in 1965 from Gov. Tawes and again a decade later from Gov. Mandel. In October, 1976, he also received the Baltimore Greek Community's First Annual Ad Hoc Award.

Married to Helen Klosteridis Padussis, Dr. Padussis' two children are Regina Padussis Panos (married to the son of Evening Sun Political columnist Lou Panos) and Stephanie Helen Padussis.

The Junior Delegate

Dr. Padussis, what is YOUR role within the AMA?

I'm proud to be the junior Delegate to the AMA and to be associated with such fine colleagues as Dr. O'Donnell and Dr. Fisher. I've been an Alternate Delegate for two and a half years, and a Delegate for one year. I'll be up for reelection in two years.

I've been appointed by the Speaker of the House to Reference Committee F, which is the Board of Trustees Advisory Committee. It meets formally twice a year and picks up any resolutions which are submitted for hearing and final approval or disapproval of the proposal to be submitted to the entire House on recommendation of the Committee for a vote. The term is three years.

There are eight Committees, labelled A through H, and this is the 6th—hence, the name. As examples of such matters considered, there's budget, membership, administration, organization and so forth. My Committee is equivalent to the US House of Representatives' Ways and Means Committee.

AMA Funds

Let's talk a bit about AMA finances.

I'd be happy to! The AMA presently is in a very stable and enviable position financially; however, there are some problems with inflation increasing AMA costs, and that position may change within the next few years.

Answering the Critics

As the youngest and junior of the

three Med-Chi Delegates, what is your response to people who say that "The AMA is a closed shop of guys who've been in there for years dictating policy, and we won't have a chance for input if we join?"

Conversely, I believe the opposite! I'm imbued with the spirit of the AMA and of Med-Chi, which is one of progressing with medicine in all its aspects in the health care fields. The AMA today has a greater influx of medical students and young residency graduates joining than ever before. On the other hand, some of the older citizens who're practicing medicine are tending to drop off, apparently preferring not to pay their dues as they get older and closer to retirement. The spirit and unity of the new members are also greater than ever before. These young leaders are polished and highly-inspired. They feel as I do that what the AMA is doing today is progressive and not necessarily conservative.

I feel everyone should join the AMA, as there's only one national voice that speaks for all medicine—and for me—and that's the AMA.

I've been broadened by my experience with both the AMA and Med-Chi.

Thank you, Dr. Padussis. ☐

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Cancer Cells

By RAYMOND J. DONOVAN, JR., MD, FACS

For reprint and other data, write Dr. Donovan at 3350 Wilken Ave., Balto., MD 21229.

Cancer cells have invaded the bone
Where they got started is not known
But spread they did to a distant part
And the doctors don't know how they got their start
I lie here thinking and moan in pain
All efforts to cure me must be in vain.
The doctors are kind and the nurses, too,
But it's clear to me there is nothing to do.
But lie here and wait for another shot
And try to figure the time I've got.
There is much to do in the time that remains
But where do I start when crippled with pains?
I never knew there were so many tests
That hospitals proudly provide for their guests.
Blood tests and scanners and awesome machines
Even technicians who catalogue genes.
Beeping and clicking the machines take my measure
While the cancer cells growing destroy what
treasure.
Floating from some place as yet unknown,
They forage for food and stick in the bone.
They said it may have begun in the breast
And tomorrow they scheduled the final test
It is "just a biopsy," he said with a smile
"It will all be done in a little while."
"We must have tissue so we know how to treat,"
The Resident reasoned and shuffled his feet.
"The biopsy will give us a definite answer,"
But what does it matter when the report says Can-
cer?
They tell me they have some marvelous drugs,
That search and destroy the cancer bugs.
But I know the drugs can't do it all,
And I lie here in pain and want to bawl.
My hair will fall out and my gums will bleed,
If I can believe the things I read.
But is that better than the stage I'm in,
I know the answer "I just can't win."
I hope they give me enough for pain,
And don't bring up addiction again.
If they can make the pain relent,
Perhaps I'll have time to truly repent.
So go ahead and make your cut
Unaware of my knotted gut.
Then tell me the verdict I knew already,
And try to make your voice be steady.
As you explain the treatment plan
Don't be afraid to hold my hand,
Because I'm the one who wants to groan
"The Cancer Cells are in my bone!"

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Intraligamentous Extrauterine Pregnancy

By H. MELVIN RADMAN, MD

For reprint and other data, write Dr. Radman at 3601 Clarks Lane, Balto., MD 21215.

Extrauterine gestation, or ectycesis, is a common disease that has been estimated to occur as often as one in every 200 to 300 cases of pregnancy;¹ however, in recent years, there seems to be an increase in its appearance and in an earlier age group. Present calculations have found ectopic pregnancy in the ratio of one to 133 live births.² The causative factors in the increase may be considered as sexual promiscuity with resultant pelvic inflammatory disease, an increase in induced abortions and the use of intrauterine devices.³ The various manifestations, diagnosis, complications and the treatment have been explored extensively and further discussion from those views could only be academic. Schumann's⁴ legendary scholarly treatise on the subject states that the intraligamentous variety of the disease is comparatively rare. Kobak, Fields and Pollack⁵ define intraligamentous pregnancy as a gestation which grows within the space made by the folds of the broad ligament. Since that type of ectopic gestation is the rarest of extrauterine pregnancies, an additional case report added to current medical publications could be of interest.

Case Report

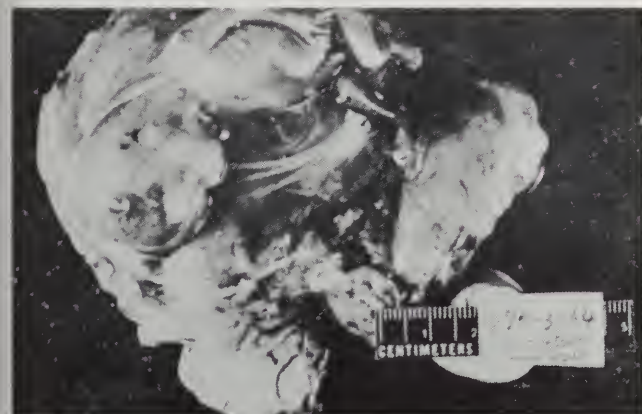
Mrs. L.B., aged 35, a para 22002, was seen on Sept. 20, 1976 with a history of delayed menses. Her periods had always been regular. She had discontinued oral contraceptives for several months and now was using a diaphragm; however, in mid-August, she had sexual intercourse without benefit of contraceptive precautions. Her last regular period was on July 29, 1976. At the initial examination, the uterus was found to be slightly enlarged. A pregnancy test was positive. The estimated date of confinement was May 6, 1977. Because of the stress of socioeconomic conditions, interruption of pregnancy was requested. On Sept. 28, 1976, the uterus was presumably emptied by suction; a small amount of tissue was obtained. The surgical pathologic report

revealed endometrium in the secretory phase with no evidence of fetal parts, placenta or chorionic villi. The Arias-Stella reaction was present. Because of those findings, an extrauterine pregnancy was suspected and the patient was alerted for signs and symptoms of rupture.

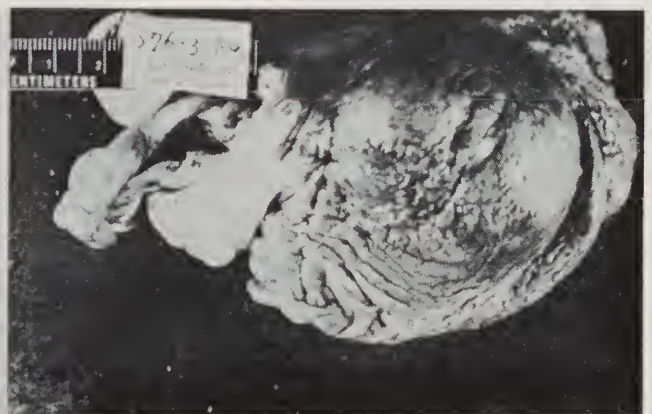
Approximately three weeks later, another pelvic examination was done and the uterus or pelvic mass had increased in size. She continued to have breast fullness, nausea and vomiting and practically no vaginal bleeding. Another pregnancy test on Nov. 4, 1976 was found to be positive. Because of continued enlargement of the pelvic mass, the positive pregnancy test and the symptoms of pregnancy further exploration of the uterine cavity was done. No tissue was obtained. On Nov. 8, 1976, the pregnancy test was again positive and on Nov. 11th, an exploratory laparotomy was done. By this time, the pelvic mass could be felt abdominally and reached two-three finger-breadths above the symphysis. At operation, an intact intraligamentous pregnancy was discovered involving the left adnexal region. The entire mass, however, was found adherent superiorly to the fundus of the uterus, and thus was explained the physical findings. A left salpingo-oophorectomy was done. Upon opening the sac, the fetus was found to measure 7 cm. (crown-rump). The post-operative course was uneventful and she was discharged from the hospital in one week.

Discussion

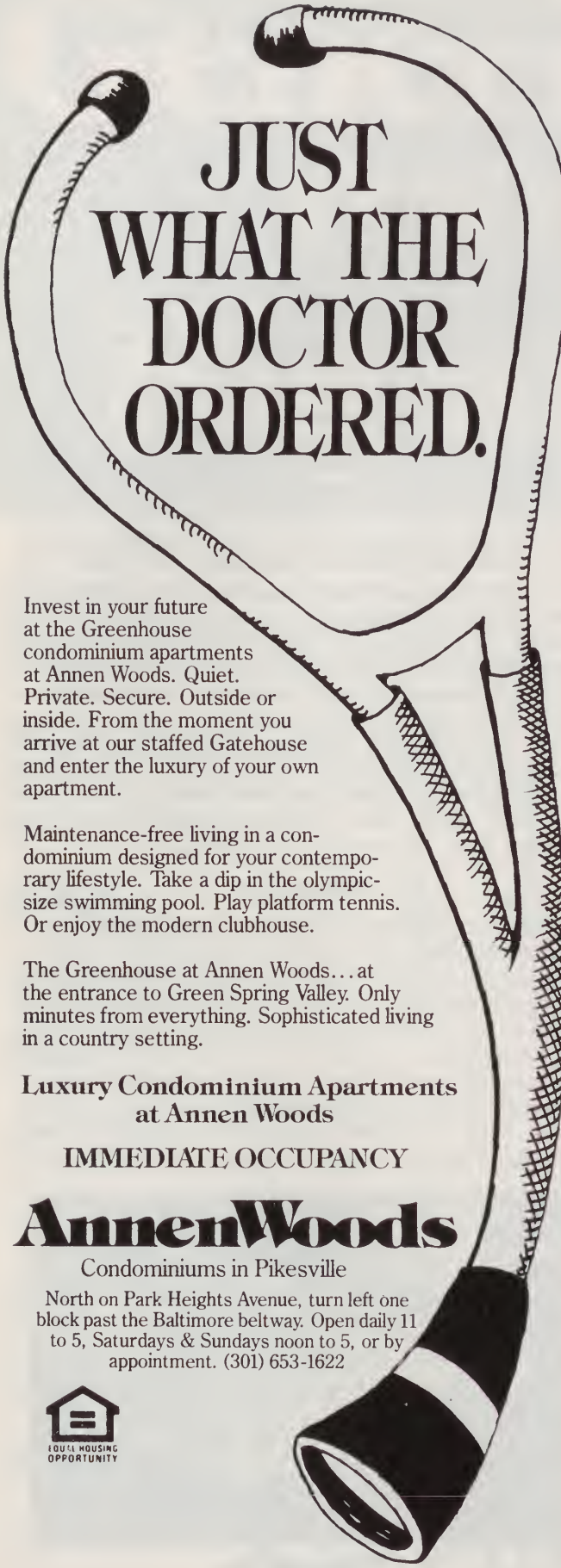
Standard textbooks and medical publications in regard to intraligamentous pregnancy give little information on the subject. When tubal rupture is somewhere along the line of attachment of the mesosalpinx the embryo is expelled and lies between the folds of the broad ligament. As stated by Novak and Woodruff, and in detail by Kobak et al, the gestational growth proceeds into the intraligamentous space. Rupture could occur with serious sequelae to the mother, or the pregnancy could continue and become abdominal. The



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necessity for postoperative evaluation as well as preoperative study of any given patient is accentuated by the train of events in this patient.

Under those circumstances, a logical approach can be made to the diagnosis and treatment of patients with similar disease entities. Of great importance and emphasis was the fact that no placental tissue or chorionic villi were found in the tissue removed at the first curettage. In addition, the Arias-Stella reaction was confirmatory, despite the appearance of the phenomenon in other than patients with extrauterine pregnancy. Continued uterine growth was noted, and thus the symmetrical enlargement of that organ made the findings misleading. When the uterus was found to be empty and the pregnancy test again positive, there could be no doubt that a pregnancy existed outside of the uterine cavity. Early laparoscopy examination might have been of help; however, laparotomy was chosen because of the certainty that the extrauterine pregnancy existed. Although the pelvic findings in this patient appeared to be misleading, in reality they were characteristic of the Ruge-Simon syndrome,⁶ consisting mainly of elevation of the affected cornu, displacement of the fundus toward the opposite side and insertion of the tube into the inferior surface of the enlargement. While the diagnosis of ectopic pregnancy at times is not difficult, it is not always easy. On occasion, the entire picture is obscure.

Because of the serious complications which may follow, it is important to treat this condition without delay. Whenever aberrant bleeding, unusual findings and adequate surgical pathologic reports are obtained, the index of suspicion should remain high.

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Installation Address, AAMSE Meeting, St. Louis, MO

By MICHAEL W. McMANUS

Mr. McManus is Executive Vice President of the Medical Society of Milwaukee County, where he can be contacted for reprint and other data at 411 E. Mason St., Milwaukee, WI 53202.

In case you haven't noticed lately, we're at war.

At the AAMSE National Education Seminar there was a very timely topic entitled *The Attack on Professionalism*. And you know what? I couldn't attend. I had to stay in Milwaukee with our officers and legal counsel doing corporate battle with the Federal Trade Commission, the State Attorney General's Office and the IRS—all at the same time!

I've spoken with many of you and learned that medical associations at all levels—including specialty societies—are being snowed under with subpoenas for Board minutes, records dealing with mediation and ethical matters, the activities of insurance advisory committees—all of which are among the most sensitive records we retain. And, as we comply, these same records are wide open to public scrutiny under the Freedom of Information Act.

Can it be mere coincidence that this is occurring throughout the country? I think not. Rather, it appears to be a well-orchestrated effort to demoralize America's physicians by neutralizing their professional associations. Pardon my paranoia, but neither do I consider it coincidence that this Federal dragnet comes immediately preceding the introduction of the Administration's National Health Insurance legislation.

It's the same Administration that has excoriated the AMA as a "major obstacle" to developing a BETTER health care system. It's the same Administration that gained page one headlines by decrying last year's 9.3% increase in physicians' fees, but it is also the same Administration that stood by silently when George Meany did but thumbed his nose in reaction to Mr. Carter's request for voluntary wage restraint, and it's the same Administration that had little comment when coalminers recently walked away with what might be a well-deserved 39% wage increase over the next three years. It is also the same Administration that is opposing antitrust exemptions to the AMA, the AHA and Federation of American Hospitals which are striving mightily to contain the costs of hospital care on a voluntary basis. Am I confused, or does this smack of political hypocrisy?

And so we await the unveiling of this *Better* health care system which the Administration has been promising. Enthusiasts of the Carter approach are planning

yet another rally in Madison Square Garden in a few weeks to raise \$5 million in promotional monies. The Administration's drum-thumpers are already publicly forecasting AMA opposition. What they fail to acknowledge is that American medicine supports National Health Insurance to the extent that it is *both* responsive *and* responsible in its approach. The AMA has sponsored comprehensive NHI legislation in the most recent Congresses, dating back to 1970.

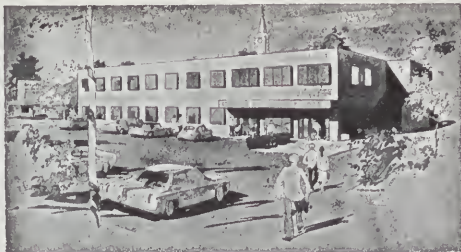
The Federal government always promises that magic word *Better*, and yet these benevolent (or is it malevolent?) bureaucrats and legislators have managed to derail Amtrak, bring Social Security to the brink of bankruptcy, and raised our postal rates 150% in less than a decade while simultaneously reducing services. Their countless and often conflicting rules and regulations now cost American business \$103 billion a year.

These financial wizards have also managed to increase the Federal budget a mind-boggling average of 318% annually for each of the past 50 years. Our property taxes have increased 111% in the last decade. Interest alone on the Federal debt costs taxpayers \$936 million each week—EACH WEEK—nearly \$50 billion a year! These are the same friendly folks who have gyped the aged by making a mockery of Medicare. It's reported that our elder citizens now pay as much out of pocket for health services as they did in pre-Medicare days—BETTER?

I know that these remarks may seem unusually harsh at an installation ceremony, but I'm convinced we've already entered one of the most extraordinary eras in our careers as med execs. AAMSE must be ready to assist each of us so that we, in turn, can provide maximum assistance to the profession we are privileged to serve. As your President, I pledge that assistance in the months ahead.

I think we need a national clearinghouse on these subpoena documents and a communications network whereby our respective legal counsels back home can share their strategies. I am also asking our Committee on Continuing Education to consult with AMA on the feasibility of a special national conference on this subject in the near future.

I only wish this unprecedented encroachment could motivate some 40% of the physicians in this country to unify within their county and state societies, and the six in 10 who remain outside the AMA. Never has the profession needed one another more. As med execs, we have both the opportunity and obligation to bring this about. Those of us who have studied the British and



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Canadian nationalized health systems on-site heard a warning loud and clear from practitioners who are now under the crushing thumb of their federal governments. If you take any message back home, they have said, tell your physicians that we lost the war because we didn't support our medical associations—especially the national association. The government negotiated with us through specialty societies and cut the profession to pieces.

For those of you who haven't had the opportunity to get this message first-hand, take it back home and give it maximum exposure. Med execs are sometimes referred to as the eyes and ears of medicine. To that I would add that we must sometimes also be the conscience of medicine, if we are to help America's physicians preserve the professional freedoms they still retain.

Physicians must also be given the opportunity to demonstrate their concern and commitment to voluntary cost containment. This is one more issue that we in AAMSE need to be addressing in the very near future, if we expect the profession to be held in the same high public esteem that physicians have earned down through the years.

Finally, as the result of last year's membership survey I believe AAMSE has a clear mandate to establish a program of voluntary certification for our members. Tomorrow, I shall ask the AAMSE Board to ratify my appointment of a special committee so that next year at this time, we can announce the availability of a certification program to our members.

I suppose I could leave you with a statement as dramatic as that issued by Abraham Lincoln to a Milwaukee audience in 1859: "Let us have faith that right makes might, and in that faith, let us do our duty as we understand it," but that isn't McManus, so I'll simply say that, like MacNamara's band, although we're few in numbers, we're the finest in the land. □

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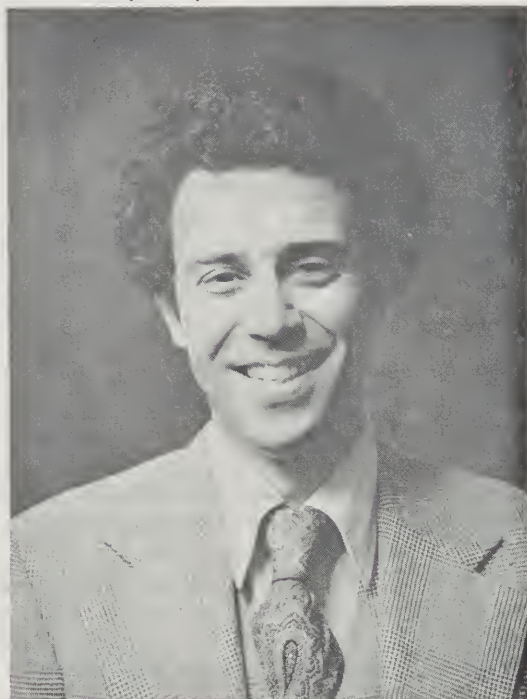
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Physician Preferences for Continuing Medical Education Programs

By CARLTON A. HORNING, PhD

This study was sponsored by the Div. of Biomedical Information Support, Extramural Programs of the National Library of Medicine, Grant LM02456-03. Dr. Horning is in the University of Maryland Dept. of Sociology at College Park, MD 20742, where he can be contacted for reprint and other data. Dr. Horning is also a staff member of the Graduate Medical Education National Advisory Committee of the Health Resources Administration of the Department of HEW, and a candidate for the MPH degree at the Johns Hopkins University School of Hygiene and Public Health.

Abstract

Primary care physicians' evaluations of Continuing Medical Education (CME) programs sponsored by community hospitals, medical societies and medical schools are assessed. The analysis shows that physicians in different primary care specialties have different evaluations of the benefits derived from programs sponsored by various agencies and that these evaluations depend upon whether the physician is seeking information relevant to his or her care of regular patients, exceptional patients or preparation for possible recertification examinations.

An examination of the multitude of CME programs and activities¹ leave one with the impression that there is less than the optimum level of systematic planning and coordination between the various sponsors of these activities (e.g., community hospitals, medical schools and national, state and local medical societies). The overlap of program content suggests a duplication of effort and a competition for participants between organizations sponsoring CME activities. Practicing physicians find themselves faced with a plethora of similar activities to choose from, none of which necessarily correspond to their needs and preferences. To this extent, these programs are an inefficient and perhaps ineffective mechanism for transferring knowledge to physicians and improving the quality of health care they deliver.

Ideally, the first step in organizing any CME activity is identifying the needs of the physicians the activity is to serve. There are several strategies for this including chart audits of hospital or office records, similar review procedures conducted in Quality Assurance Programs or Professional Standards Review,² epidemiological methods, IMP as reported by Wooley and Wooley,³ as well as formal or informal surveys of physicians as to what they perceive their needs to be.⁴⁻⁵ It is not our point to debate the relative advantages and disadvantages of these or other needs-identifying strategies⁶ except to note that an effective strategy determines whether there is a need for CME addressed to the care of regular patients, the care of exceptional patients or, more general education, for example, as preparation for possible recertification examinations. Further, an

effective strategy will also delineate the medical specialty for which the need is greatest as well as the geographic region (i.e., rural or urban physicians) in which the need is most acute. For example, chart audits of hospital records may reveal a problem in the diagnosis or treatment of pediatric pneumonia. This implies a need for CME programs that will convey the relevant knowledge to the appropriate audience; in this case pediatricians, general practitioners, family practitioners and allied health care professionals who are likely to come into contact with the patient.

Once physician needs are identified and delineated, individuals who are responsible for providing CME are confronted with the problem of designing an educational program that will maximize the improvement in patient care. Presumably, this goal will be achieved by optimizing information transfer. This involves attracting the maximum number of physician participants not to mention other health personnel, by designing a CME program that is matched to the preferences of the greatest number of physicians in the target population.

Mason and Kappelman⁷ reported data collected from the directors of CME at the nation's medical schools that is worthy of review in the context of this discussion. They found that 62% of the topics for CME programs that the CME directors considered to be "successful," were designed to meet physician needs as identified by the organizers of the sessions while another 28% addressed needs identified by the participants. In only two instances were programs designed to meet needs identified by chart audit of hospital or office records. Moreover, Mason and Kappelman's data showed that over one-third of these programs were directed towards all practicing physicians, about 25% were directed towards practitioners of a given medical specialty and another 25% were aimed at family practitioners. Further, nearly two-thirds of these "successful" programs were conducted at health science centers while only 18% were offered at local hospitals with nearly an equal amount offered at hotels and resort areas.

The analysis reported here examines practicing physicians' evaluations of CME programs sponsored by various agencies in terms of which agency offers CME programs that they feel are the most beneficial to them in caring for regular patients, exceptional patients and in preparation for possible recertification examinations.

Data and Method

The data reported by Mason and Kappelman in their study of the perceptions of effective CME program among CME directors at the nation's medical schools

were collected as part of a much larger study of the *Information Needs of Practicing Physicians*. The major thrust of the larger project was to determine the utilization patterns and preferences for alternative modalities and programs of CME among physicians in office-based primary care practices.

Lengthy questionnaires were distributed to a random sample of physicians in Maryland who, according to the American Medical Association's Physicians' Records Information System, identified themselves as practicing: family medicine, general practice, internal medicine, general surgery, obstetrics/gynecology, pediatrics or psychiatry. Responses were obtained from 651 office-based physicians which amounted to a response rate of 31%. A detailed examination of respondents vis a vis nonrespondents showed that the responding sample was representative of the population and the contacted sample with respect to medical specialty, type of office practice (i.e., solo, partnership, group, etc.), and geographic location; however, the responding sample was somewhat biased with respect to age. Physicians in the age cohorts 36-45 were underrepresented among respondents, while physicians between the ages of 56-65 were overrepresented (Chi Square "Goodness of Fit" Tests are available from the author upon request).

There may indeed be some latent benefits to be derived from the misrepresentation of the different age cohorts. Although we cannot state definitively why physicians between the ages of 36-45 responded to the survey at a lower rate than expected or why those between the ages of 56-65 responded at a significantly higher rate than expected, we can suggest that older physicians who have been practicing medicine for approximately three decades are more likely than their younger colleagues to feel a need to keep abreast with recent developments in the field of medicine and therefore respond to a time-consuming questionnaire that asks them to evaluate the utility of various modalities of CME (e.g., teaching rounds, video tapes, audio cassettes, computer-assisted instruction, etc.) and to evaluate the potential of these modalities as learning devices in the future. In contrast, younger physicians may

regard themselves as being knowledgeable about the current state of the art by virtue of their recent completion of their medical education, apparently chose not to take time from their busy schedules to spend an hour answering a questionnaire about a topic with which they have had only limited experience and which is not defined by them to be of immediate importance to their practice of medicine. To the extent that this interpretation is accurate, then an overrepresentation of older physicians among respondents is a potential benefit because these are the physicians who are likely to have had the most experience with alternative modalities and sponsors of CME and feel the greatest need to keep abreast of current technological developments. Moreover, by virtue of their experience with CME programs and technologies, they are precursors of the experiences and needs of today's younger physicians.

Results

Table 1 gives the percent of physicians in each primary care specialty who regard the various sponsors as the source of CME activities that are the most beneficial to them for their routine practice of medicine. With the exception of family practitioners and psychiatrists, approximately 40% of primary care physicians evaluate the programs offered by community hospitals as the most beneficial for their routine medical practice; however, other than general practitioners and internists, only about one in four physicians in the other primary care specialties regard medical school-sponsored programs as being the most beneficial. It is noteworthy that local and state medical society-sponsored programs are rarely defined as the best source of CME for regular care. Similarly, "other" sponsors of CME activities, such as private enterprises, are not seen as offering primary care physicians other than psychiatrists programs that are beneficial for routine practice. Perhaps the most noteworthy observation is that general practitioners are quite like internists and quite unlike family practice physicians in their evaluations of the various sponsors. General practitioners, like internists, are about twice as likely as family practice physicians to

Table 1:
Sponsor of the Most Beneficial Programs for Care of Regular Patients by Medical Specialty (Percent)

	Family Practice	General Practice	General Surgery	Internal Medicine	Obstetrics/ Gynecology	Pediatrics	Psychiatry	Total (n)
Community Hospitals	22.9	44.0	33.7	41.7	39.5	39.5	18.4	37.3 (121)
Local and State Medical Societies	8.6	7.2	0.0	2.3	3.5	1.2	1.3	3.4 (20)
Specialty Societies	37.1	8.8	34.5	13.6	32.6	27.2	34.2	23.3 (138)
Medical Schools	25.7	36.8	22.4	39.4	19.8	29.6	15.8	29.2 (173)
Other	5.7	3.2	3.4	3.0	4.7	2.5	30.3	6.9 (41)
Totals (n)	100.0 (35)	100.0 (125)	100.0 (58)	100.0 (132)	100.0 (86)	100.0 (81)	100.0 (76)	100.0 (593)

$\chi^2 = 139.48, d.f. = 24$
 $p < .001$
 $\lambda = .046$

see community hospital-sponsored programs as the most beneficial to the care of their regular patients. In contrast, family practitioners are about four times more likely than general practice physicians and three times more likely than internists to look to state and national specialty societies for CME programs for care of their regular patients.

In Table 2 we see the evaluations of sponsors of programs for care of exceptional patients. The pattern of evaluations is generally the same and the magnitude of association is, for all practical purposes, equal. In general, there is a shift away from community hospitals as the source of the most beneficial programs for care of exceptional patients. This shift is most pronounced among surgeons, 40% of whom regard community hospitals as the best source for care of regular patients but only 18% of whom see community hospitals as offering programs that are the most beneficial for treating special problem cases. A similar shift, from 42-26%, is also evident among internists. Only general practitioners and psychiatrists show little change in their evaluation of the benefit of community hospital-sponsored programs. There is also little change in the evaluation of programs sponsored by local and state medical societies. Again, less than 4% of the physicians see these programs as most beneficial, although family practitioners and general practitioners evaluate these programs more favorably than other specialists. While there is also little overall change in the percentage who think specialty societies offer the most beneficial programs for regular and exceptional care, there is a significant shift among family practitioners. For programs that are beneficial for the care of regular patients, 37.1% of the family practice physicians see their state or national specialty society as sponsoring the best programs, but when it comes to programs relevant to the care of exceptional patients, only 16.1% define these societies as the best providers.

The overall decline in the evaluation of community hospital-sponsored programs is concurrent with an increase in the favorable evaluation of medical school-sponsored programs. When it comes to care of problem

cases, more than one-half of the family practitioners, internists and pediatricians, as well as about one-third of the general practitioners and surgeons, and one-quarter of the obstetricians/gynecologists and psychiatrists regard the programs sponsored by medical schools as the most beneficial for their care of special cases. The shift towards medical schools for this kind of CME is particularly strong among family practitioners (29.7%) and pediatricians (21%), while general practitioners and surgeons tend to shift toward "other" sponsors, though not dramatically so.

The final Table shows the evaluation of programs in terms of their benefits for preparing for recertification examinations. Although such examinations may or may not come to be mandatory for all physicians, it is nevertheless important to see how physicians evaluate past programs sponsored by the various agencies in order to anticipate physician preferences if and when recertification examinations become required. We anticipated that medical schools and specialty societies would be the sponsors that physicians would turn to overwhelmingly for CME programs to assist them in preparing for examinations simply because of the role of medical schools and specialty societies as harbingers of medical knowledge. Similarly, we anticipated that physicians would become less dependent on community hospitals and local and state medical societies for programs designed to familiarize them with highly specialized knowledge.

When we compare Tables 2 and 3, we note that these predictions are not entirely accurate. State and local societies lose little of the physician market if only because of the small part of the market they hold for CME designed to meet either needs for the care of regular patients or needs for the care of exceptional patients. The overall shift away from community hospitals is similarly small. In fact, contrary to expectations, surgeons, obstetricians/gynecologists and, especially, pediatricians, are more likely to see community hospitals as the sponsor of the most beneficial preparatory programs than they were to see them as sponsoring the most beneficial programs for special cases. More-

Table 2 :
 Sponsor of the Most Beneficial Programs for Care of Exceptional Patients by Medical Specialty (Percent)

	Family Practice	General Practice	General Surgery	Internal Medicine	Obstetrics/ Gynecology	Pediatrics	Psychiatry	Total (n)
Community Hospitals	12.9	37.0	17.9	25.8	26.0	16.9	16.4	24.2 (136)
Local and State Medical Societies	6.5	9.2	0.0	2.3	3.9	1.3	1.4	3.7 (21)
Specialty Societies	16.1	8.4	41.1	18.0	37.7	28.6	28.8	23.7 (133)
Medical Schools	54.8	35.3	32.1	50.0	27.3	50.6	23.3	38.9 (218)
Other	9.7	10.1	8.9	3.9	5.2	2.6	30.1	9.4 (53)
Totals (n)	100.0 (31)	100.0 (119)	100.0 (56)	100.0 (128)	100.0 (77)	100.0 (77)	100.0 (73)	100.0 (561)

$X^2 = 118.69, d.f. = 24$
 $p < .001$
 $\lambda = .058$

over, the increase in the percentage of pediatricians regarding community hospital-sponsored programs as most beneficial (16.9%-28.2%) is nearly equal to the decrease in the percentage of pediatricians (50.6%-42.3%) who regard medical school-sponsored programs as the most beneficial.

The absence of clear differences between the evaluation of programs for exceptional care and preparation for recertification examinations probably reflects either confusion physicians feel over if and when recertification examinations will become required, or, an anticipation that any examinations that are required will test medical knowledge pertaining to the care of exceptional patients rather than the routine practice of medicine or the very latest esoteric information. Our anticipation of an increased reliance on medical schools and specialty societies may yet prove to be correct, particularly if either of these institutions come to play a central role in determining the form and content of recertification procedures.

Discussion

The analysis that we have presented only touches one part of the complex problems involved in planning CME programs that will enable physicians to provide better health care. Furthermore, the results must be interpreted with an element of caution owing to the fact that the data on physician evaluations come from only one state and therefore are attitudes formed from experiences with a much smaller number of CME programs than that which formed the basis of the opinions analyzed by Mason and Kappelman; however, it should also be noted that five medical schools and well over 100 community hospitals serve the CME needs of physicians in our survey and, consequently, there is some variance and diversity in the types and quality of programs that form the basis of their evaluations.

To the extent that we can generalize from these data, we can suggest that the perceptions of those responsible for medical school-sponsored programs are not entirely congruent with the perceptions and preferences

of practicing primary care physicians. While one third of the medical school-sponsored programs are aimed at all physicians without regard to their practice specialty, our survey tells us that there are appreciable differences between medical specialties in terms of how they evaluate the benefits of programs sponsored by medical schools and other organizations.

This suggests that directors of CME at medical schools, as well as those at community hospitals and medical societies, can better serve practicing physicians by designing programs that are more "specialty-specific." For example, a distinction is rarely made between family practitioners and general practitioners, while general practitioners are typically distinguished from internists, yet our results indicate that when it comes to CME programs, particularly those that are designed to meet the needs of a physician's routine practice of medicine, the preferences of general practitioners are significantly different from those of family practice physicians, but quite similar to those of internists.

Directors of CME should become sensitive to such patterns and structure their programs accordingly. Furthermore, program directors can plan more appealing programs by being cognizant of what kinds of CME needs physicians look to them to fill, instead of trying to be all things to all doctors.

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Table 3:
Sponsor of Most Beneficial Programs for Preparation for Possible Recertification Examinations by Medical Specialty (Percent)

	Family Practice	General Practice	General Surgery	Internal Medicine	Obstetrics/Gynecology	Pediatrics	Psychiatry	(n) Total
Community Hospitals	5.7	28.4	18.5	24.8	27.4	28.2	10.1	22.7 (125)
Local and State Medical Societies	0.0	8.3	1.9	3.3	2.4	2.4	1.3	3.3 (18)
Specialty Societies	34.3	9.2	38.9	14.9	34.5	26.9	40.6	25.3 (139)
Medical Schools	51.4	46.8	33.3	52.1	31.0	42.3	21.7	40.7 (224)
Other	8.6	7.3	7.4	5.0	4.8	1.3	26.1	8.0 (44)
Totals (n)	100.0 (35)	100.0 (109)	100.0 (54)	100.0 (121)	100.0 (84)	100.0 (78)	100.0 (69)	100.0 (550)

$$X^2 = 105.53, \text{ d.f.} = 24$$

$$p < .001$$

$$\lambda = .058$$

Acknowledgments

I would like to thank Michael Massagli, William F. Jessee, MD; B. Claire McCullough and Josk L. Mason, PhD for comments on an earlier draft of this paper. ☐

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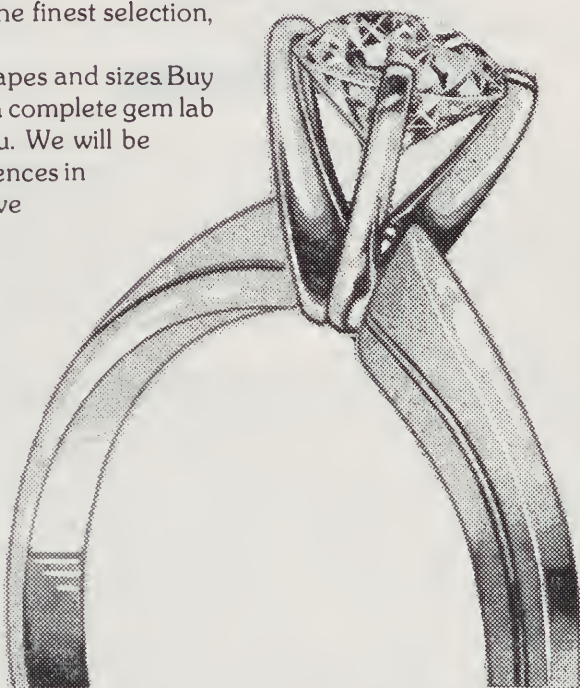
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CONRAD ACTON, MD, Editor

January Meeting

1979's new and highly-charged Board of Directors held its January Meeting on the third Tuesday. Minutes were all right from the December, 1978 Meeting, but the routine of making nominations for the Community Service Award was deferred until more names could be submitted. This Award is made at the Med-Chi Annual Meeting. It recognizes non-medical, community-benefitting works.

A proposal to study Baltimore medical practices in the offices of ALL private practitioners brought lively discussion. Doctoral candidate Jonathan Weiner explained his study outline which is the basis for his doctoral thesis. The health service problem situation, as he sees it is 1) inadequate primary care and 2) an absolute lack of quantitative information about the delivery of primary care by private practitioners due to their decentralization (or independence.)

His study proposes a 100% census of all 4,464 physicians in Baltimore. Initial contact will be by mail. The non-responders will be followed-up. Also, some pre-collected data will be worked in.

Cost is estimated at about \$20,000, without overruns. It will be paid by BCMS and possibly some other agencies including Hopkins University, Med-Chi, the MSHPD Agency and even CMHSA could help.

The Directors were particularly questioning the expected time the study would take and its possible influence on this year's Legislature; how confidentiality would be maintained; methods to avoid bias/skewing of statistical interpretations. The expected response rate was up to about 70%, especially without questions of costs and quality factors.

Mr. Weiner proposed that 12 months should be allotted. He promised that monthly progress reports would be sent. The Directors approved the project.

Legislative Committee

The Legislative Committee had recommendations about upcoming legislation on abortion and on podiatric practice. The Committee feels that it is manifestly unfair, with regard to abortion, to restrict the use of public funds in such a way as to deny services to the poor and permit them to the affluent. This would be the case if welfare funding of abortions were stopped.

The Legislative Committee feels that the Bill broadening the scope of podiatric procedures would encourage practices for which many podiatrists are untrained. It has always been difficult to draw practice boundaries, but "examination, treatment and prevention of diseases, conditions and malfunctions affecting the human foot and its related or governing structures, by employment

of medical, surgical or other means," does seem awfully broad. After all, the brain is a governing structure of the foot as well as the rest of the body.

Another Legislative Committee recommendation attempted to debride some of the red tape connected with autopsies and organ-retrieval. The Board of Directors supported all of the Committee's recommendations.

A quotation in the press derogatory to physicians in general was brought to the Directors' attention. A member of the State Health Services Cost Review Commission is directly quoted in the press release as saying: "Physicians are resisting change because they want to limit competition in order to make more money themselves. . . They don't want to consider alternate ways and the reason they don't want to is economical—they're afraid they won't be able to buy a new Cadillac next year." Such bias by a State official is hazardous to the planning process and to patients to be affected by his logistics in hospitals throughout the state. Ways to offset and correct the effects of this attitude were considered, but none decided upon. Possibly, a logical way would be to have a greater number of physicians on the HSCRC.

Plans for our Annual Meeting in December are already under scrutiny. Sentiment for a location in Baltimore continues strong. Baltimore's new Convention Center's availability is chancy. Costs in other suitable arenas downtown are generally higher than our traffic would seem to bear. Having the meeting and awards at Center Stage was proposed as a change for the better. The meal could be catered. Costs would be about the same as in the past few years. A seasonal play, perhaps *A Christmas Carol*, could be a very added attraction. The Directors approved, and staff was directed to make the arrangements.

Directors Meet

The Directors met on the last Tuesday in January with H. McDonald Rimple, MD, and had a refreshing and open exchange of views. Dr. Rimple is an Assistant Surgeon General and Director of Region III of the Regional Health Administration for HEW. He is ex officio in charge of health planning activity for the mid-Atlantic area, which comprises Pennsylvania, Maryland, Delaware, the District of Columbia, Virginia and West Virginia.

Informal discussion revolved about the roles of individual physicians and of local/state medical societies in the health planning process. The Health Planning and Resources Act (93-641) Dr. Rimple saw as inevitably-changing medical practice. Centering on prevention and cost containment, Dr. Rimple quoted statistics projecting an excess of physicians of about 2,000 as one basic excess cost of medical care. Maldistribution, low minority ratios and high specialization rates were all seen to be contributing factors. Dr. Rimple admitted that the National Guidelines that emanated from Washington often ran contrary to local necessity. He ascribed this to interests within the HSA that overruled its own staff's findings and recommendations. When it was pointed out, for instance, that there are 11 CAT scanners on the NIH campus, while many Baltimore area hospitals were actively denied them, he was hard put to

reconcile this with policies of lower costs and higher quality!

A staunch supporter of HEW Secretary Joseph Califano, Dr. Rimple favors and promotes formation of HMOs to replace fee-for-service practices. Dr. Rimple announced that all the HSAs have now been formed. Their major initiatives at this time are 1) Tracking Systems, 2) immunization programs and 3) Teenage pregnancy.

In the discussion it seemed agreed that the socioeconomic pressures of consumer choice often ran counter to a physician's duty to a patient. Also, the data for evaluating the excess of insufficiency of physicians in any area was patently inadequate. For instance, the area surrounding the University Hospital is officially designated as underserved by primary care physicians, but it has also been held to be too expensive, adding unnecessarily to the cost of medical care, to validate or correct!

The fantastic inconsistency and irrelevance of Health Regulations, and the cost of complying with Health Regulations actually conflicting with one another, each with the status of law until taken to court, was pointed out to Dr. Rimple with chapter and verse. Round and round it went and, while the *goals* of quality care, low cost and supply abundance were acceptable to all, it became obviously a matter of definition and criteria and of reconciling 180° differences about supply and demand at every level of health care delivery.

February Meeting

The first general meeting of the BCMS for 1979 was Feb. 1st. President Albert M. Antlitz, MD called the meeting punctually to order. He announced the recipients of Med-Chi's 40-year Member Certificates, and they were:

Harold C. Dix, MD
Samuel J. Hankin, MD
Robert F. Healy, MD
William G. Helfrich, MD
Albert J. Himelfarb, MD
Manuel Levin, MD
William Kenneth Mansfield, MD
Louis R. Maser, MD
M. Elliott Randolph, MD
Daniel Wilfson, MD

Richard Berkowicz, MD, Chairman of the Professional Relations Committee, reported his Committee's work of the past year. Basically, its charge has to do with reconciling physician-patient differences and misunderstandings. Dr. Berkowicz' statistics included 190 complaints against a total of 117 physicians straightened out by his Committee.

William J. McClafferty, Jr., read the Legislative Committee's report recommending some housekeeping changes in the Bylaws. They were routinely passed and will come up for final action at our next meeting.

President Antlitz reported on the upcoming study of primary care in physicians' offices in Baltimore. Every physician will be expected to participate, initially by questionnaire.

Dr. Glaser Speaks

Kurt Glaser, MD, Associate Professor of both Pediatrics and Psychiatry at the University of Maryland School of Medicine, gave the scientific paper of the Meeting. His presentation on *Depression and Suicide in Adolescents* was well-received. Adolescents he defined as the 15-24 year-old group. If physicians are going to be able to identify adolescents at risk, they must be able to do a "psychological autopsy" on those they advise. With depressed adolescents under therapy, there is a 40% success rate, but this connotes a 60% failure rate in spite of treatment. The number of cases has increased 20% in the past year. They must be diagnosed before they can be treated. Dr. Glaser noted the confusing and conflicting statistics about the significance of such items as drugs, war, peace and religion as the precipitating factors in suicidal depression in adolescents.

Psychoanalytically considered, other causes would be feelings of loss and abandonment by parents and loved ones, loss of childhood and its privileges and changed self-esteem.

Secondly, Dr. Glaser stressed prevention. At regular or annual examinations, the physician must be sensitive to patient communication. He must especially strive to get the patient to verbalize. He must not cut off spontaneous—though seemingly irrelevant—talk. Watch out for non-verbal communication as well. Try to find out what underlies the adolescents' seeming non-sequiturs. Additional insight may be gained by noting mood changes and considering changes in job performance.

Although the physician must be on guard against manipulative adolescents (as well as adults), he may gain some idea of the depth of a depression in various ways. Hostility toward the examiner, or others, and lowering of self-esteem can justly point to gathering depression. Any defensiveness shown is important. History of delinquencies and of temper tantrums, or outbursts against people or things can reveal the presence of pressures too great for the individual to cope with. A sustained drop in school grades and inability to make friends among his peers are significant, too.

Suicidal threats as compared to actual attempts are hard to evaluate as to whether they should be considered real or manipulative. The apparent depth of the depression should be considered in light of the individual's resources, both inner and outer. Also, the degree of situational stress factors should be noted: whether small or large in relation to the patient's reaction to them.

The physician's therapeutic role with adolescents should be to guide and help toward *attainable* goals. Above all, the physician must be *alert*. □

Doctors Take Note: Upcoming Meeting

May 5, **Controversies in Management of the Critically-Ill**, sponsored by Crit. Care Service, Prince George's Genl. Hosp. and Med. Ctr., Cheverly, MD, where the symposium will be held in the Auditorium. For details, call (301) 341-6470. □

Emphysematous Cholecystitis

By LEE GOODMAN, MD

Assistant Professor, University of Maryland Hospital

This 38-year-old male presented to the Emergency Room with a one-day history of nausea, vomiting and epigastric pain radiating to the back. On examination, he was noted to have a temperature of 102° F and severe epigastric and right upper-quadrant tenderness. A white blood cell count was 19,500. The following supine

and erect abdominal radiographs were obtained (Figure 1). These were incorrectly interpreted as a "non-specific gas pattern" with gas in the stomach, duodenal cap and colon.

The next morning, a follow-up series of abdominal radiographs was obtained which clearly revealed the



FIGURE 1: Supine and erect films taken on admission.

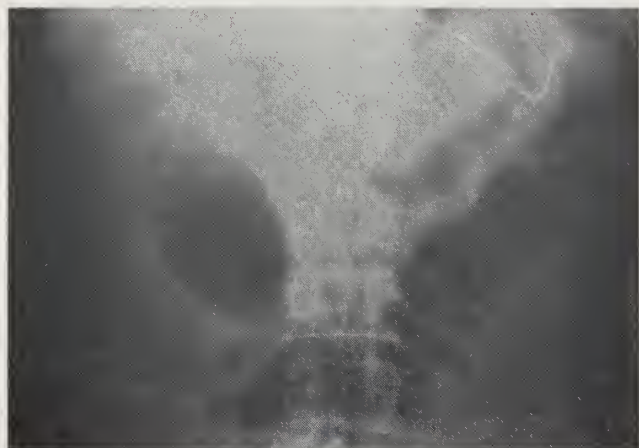


FIGURE 2: Supine film the following morning showing gas within the gallbladder and outlining the gallbladder.

diagnosis (Figures 2 and 3). What are the radiographic findings, and how would you treat the patient?

1. What is your diagnosis? Differential diagnosis?
2. What further radiographic studies (if any) would you request to confirm this?

Answer on page 66.

THIRD WILLIAM S. BAER LECTURE MAY 2-3, 1979

A lectureship honoring the late Dr. William S. Baer has been established as a memorial to him. Dr. Baer was the first Professor of Orthopedic Surgery at the Johns Hopkins Hospital and a founding father of American orthopedic training. He was the prime force in the establishment of the Children's Hospital in Baltimore.

The third Baer lecturer will be Dr. Frank E. Stinchfield, Head of Department and Professor of Orthopedic Surgery, Columbia-Presbyterian Medical Center, New York. He will arrive in Baltimore on Wed., May 2, 1979 and will be attending the Johns Hopkins Hospital Clinics on Thursday and Friday. He will lecture at 5 PM on Thurs., May 3, 1979 at the Children's Hospital.

The Third Baer Lecture will be on Friday, May 4, 1979 at 5 PM in Hurd Hall at Johns Hopkins Hospital. ☐

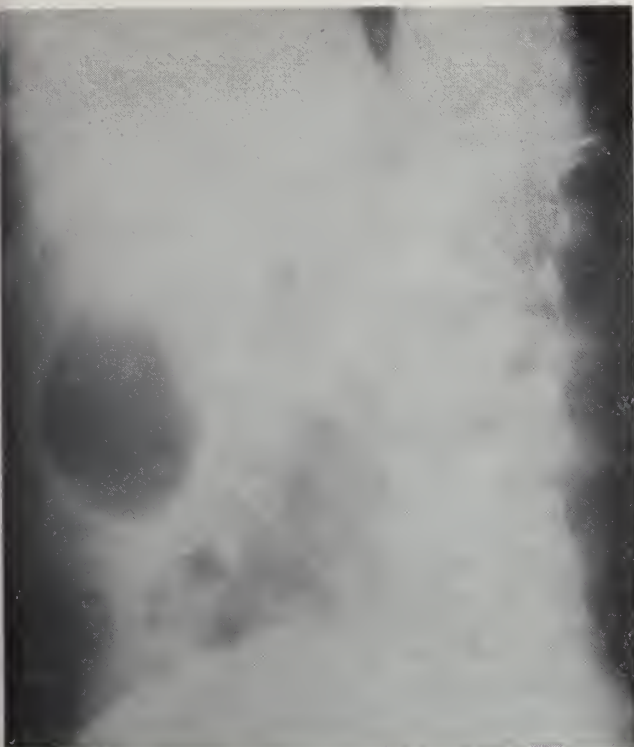


FIGURE 3: Oblique film confirming gas within the gallbladder lumen as well as the gallbladder wall.

Doctors Take Note: Upcoming Meeting:

Apr. 24, Tng. Staff for Patient Educ., sponsored by the MD Hosp. Educ. Inst., Internatl. Hotel, Balto.; for details, call (301) 321-6200.

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Radiological Case of the Month

Case history on pp. 64-65.

Discussion

As noted, the initial films were felt to reveal non-specific gas accumulations within the bowel. The prominent air-fluid level in the right upper-quadrant, however, is a bit too large for the duodenal cap. With a clinical history pointing to gallbladder disease, one should consider that this gas is located within the gallbladder lumen. In addition, on the initial supine film, there is a suggestion of a small, linear streak of gas just lateral to the large bubble. This would suggest gas within the gallbladder wall. On the films the following morning, one can readily note gas within the gallbladder lumen as well as in the gallbladder wall. The diagnosis, therefore, is emphysematous cholecystitis, and surgery is generally recommended.

Emphysematous cholecystitis is virtually impossible to clinically distinguish from the more common, simple, acute cholecystitis. Symptoms are identical, with the possible exception of a more septic presentation and a higher temperature in the emphysematous variety; also, there is a male predilection in emphysematous cholecystitis as opposed to acute cholecystitis' predilection for females. In emphysematous cholecystitis, there is a lesser correlation with gallstones, and a higher percentage of these patients have diabetes mellitus.

Generally, gas can be found in three different locations in the biliary tract: in the gallbladder lumen, in the gallbladder wall and in the bile ducts. The specific location of the gas can provide a clue as to the under-

lying pathology.

Basically, there are three mechanisms for gas accumulation in the biliary tract. The most common is termed an "internal biliary fistula," where there has been a fistulous communication between the gallbladder or common duct and the duodenum or colon. This is seen following erosion of a gallstone through the portion of the biliary tract into the gut. Often, the presence of gas in the biliary tract is an incidental finding on a film taken for a completely unrelated reason. The gas in this process will be confined to the gallbladder lumen or bile duct and not the gallbladder wall.

The second mechanism is for gas to enter the biliary tract through an incompetent sphincter of Oddi. This may be developmental or may be secondary to previous surgical sphincterotomy. This is a benign condition, and, once again, the gas will be confined to bile ducts and gallbladder lumen, depending on patency of the cystic duct.

The third mechanism, that of emphysematous cholecystitis, is the only one in which gas is seen in the wall of the gallbladder as well as the gallbladder lumen. Very rarely, one may find gas in the bile ducts, but this is most unusual. Specifically, it is still unclear why gas accumulates in the wall and lumen of the gallbladder. Certainly, gas-forming organisms play an important role. These organisms include Clostridia, Staphylococcus and Streptococcus. The underlying abnormality, however, may be an obstruction of the cystic duct with resultant distension of the gallbladder, and then ischemia. The increased incidence of this disease in diabetics might suggest that vascular occlusion of the small arteries in the gallbladder play a role in the ischemia.

The diagnosis of emphysematous cholecystitis can usually be made on the plain films alone. When there is a question of whether a suspicious gas bubble is in the bowel or possibly in the gallbladder, oblique films as well as barium studies may be helpful. Gas in the wall of the gallbladder is **NEVER** as insignificant finding. In classic cases, an oral cholecystogram, as well as an intravenous cholangiogram, are unnecessary and would only serve to delay surgery. Regardless, they would be expected to demonstrate "non-visualization of the gallbladder" because of occlusion of the cystic duct.

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Doctors Take Note: Upcoming Meeting

June 7-9, 2nd Anl. Internatl. Psychohistorical Assn. Conven. NY City Coliseum, Holiday Inn, 440 West 57th St., NY, NY 10019. Address correspondence, inquiries and paper proposals to the Convention Chairman, Dr. David Beisel, Dept. of Soc. Sci./Psych., Rockland Com. Coll., 145 College Rd., Suffern, NY 10901.

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

0-3921 (TS87A)

**Whether overweight is a
complicating factor...
or just uncomplicated overweight.**

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice¹ And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

Merrell

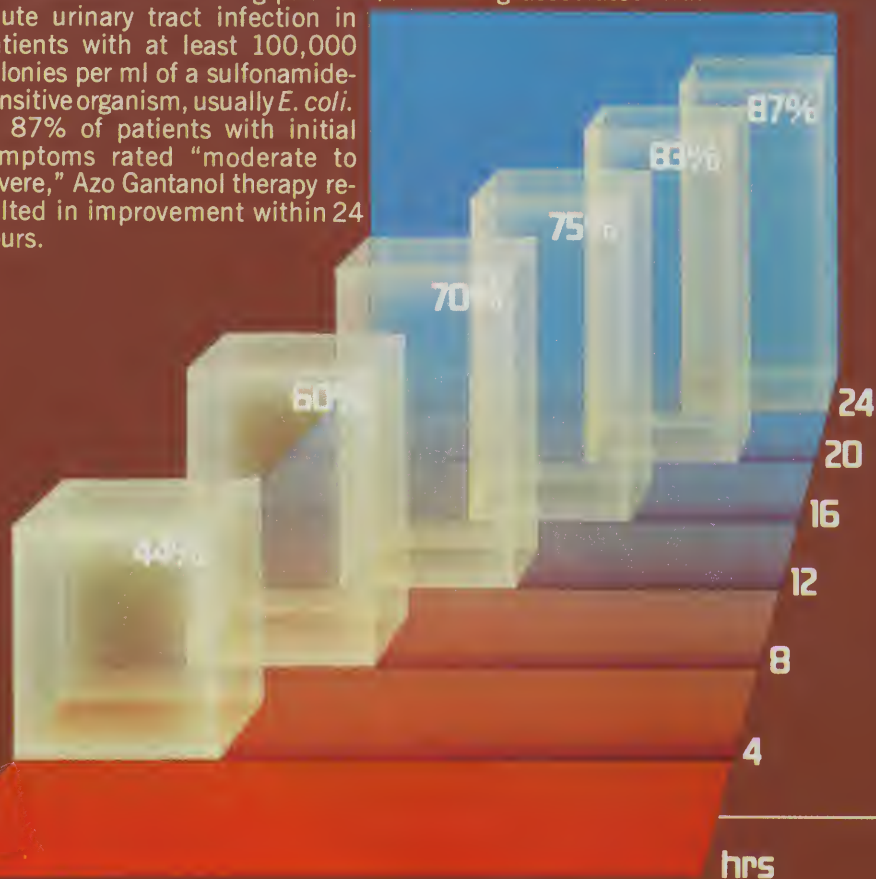


For prescribing information see opposite page.

Important data on the pain of acute cystitis:

In 87% of patients studied (303 of 349), Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for
the pain

for
the pathogens

Before prescribing, please consult complete product information, a summary of which follows:
Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note:** fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; aminobenzoic acid to follow-up culture media; increasing frequency of resistant organisms to the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood level; variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatic uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria or stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, anaphylaxis, sensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral glycosidic agents, sulfonamides have caused instances of goiter production, diuresis and glycosuria. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the painful phase of urinary tract infections. **Adult dosage:** 2 Gm (4 tabs) initially, then (2 tabs) B.I.D. for up to 3 days. If pain persists causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche
Nutley, New Jersey 07110

contains no aspirin

tablets
Darvocet-N[®] 100 (IV)

100 mg. Darvon-N[®] (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

700565

*Additional information available
to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46206*

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

**ready to do more
able to do more...**



with symptomatic relief of moderate anxiety with depression

Rapid relief of the symptoms of moderate anxiety in many patients

The tranquilizer component alleviates symptoms of anxiety and agitation within a few days, without apparent dulling of mental acuity. Hypnotic effects from the tranquilizer component appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Highly effective antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

Increased activity potential often results from symptomatic relief

As the symptoms of anxiety and depression respond to TRIAVIL, many patients may show renewed interest in family and recreational activities and are able to function more effectively at work.

More prescribing convenience

For optimal flexibility there are now *five* tablet strengths of TRIAVIL for ease of dosage adjustment. For initial management of patients with moderate anxiety and depression, one TRIAVIL® 2-25, containing 2 mg perphenazine and 25 mg amitriptyline HCl, t.i.d. may often be adequate. TRIAVIL® 4-50, containing 4 mg perphenazine and 50 mg amitriptyline HCl, provides b.i.d. convenience for those patients needing the larger total daily dose of 8 mg perphenazine and 100 mg amitriptyline HCl as initial or maintenance therapy.

Treatment with TRIAVIL— a balanced view:

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to overdose of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

For moderate
anxiety with depression
dual-action
Triavil®

containing perphenazine and amitriptyline HCl

MSD
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SHARP
&
DOHME

*Please see following page
for a brief summary
of prescribing information.*

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More dosage strengths
than any other formulation containing
a tranquilizer and an antidepressant

Dual-action Triavil®

containing perphenazine and amitriptyline HCl

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J8TR31 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

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& DOHME



Dyazide[®]

Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense in Hypertension^{*}

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-nolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
a SmithKline company

Carolina, P.R. 00630

**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl[®]

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Bentyl®**(dicyclomine hydrochloride USP)**

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20mg) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Ocatuor, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Medical Miscellany

Guidelines for Physicians Attending Patients In Long-Term Care Facilities

Foreword

Physicians attending patients in long-term care facilities are responsible for the delivery and maintenance of quality medical and health care for their patients. These physicians accept and discharge their responsibilities in conjunction with the patient care and administrative policies of the facility.

To assist physicians and long-term care facilities in providing high quality health care, the House of Delegates of the American Medical Association on two previous occasions adopted reports by the Council on Medical Service dealing with this subject. In 1959, the House adopted **Guidelines for Medical Care in Nursing Homes and Related Facilities** and in 1973, a report titled **Guidelines for a Medical Director in a Long-Term Care Facility**.

The 1973 report recommended that "Long-term care facilities should have either a medical director and/or an organized medical staff," and included guidelines for a medical director in a long-term care facility suggesting duties that he should fulfill. These guidelines recognized that physicians with patients in a long-term care facility seldom organize themselves into a formal medical staff and that where a medical director has been appointed in a nursing home, he ordinarily has functions that in the hospital are performed by an organized medical staff.

Skilled nursing facilities participating in Medicare and/or Medicaid as of January, 1976, are required to retain a physician to serve as a part-time or a full-time medical director. Federal regulations state that "If the facility has an organized medical staff, the

medical director is designated by the medical staff with the approval of the governing body." The Council on Medical Service believes that, in order to achieve more physician involvement in nursing

home care and to implement the medical director requirement for skilled nursing facilities, it is important to identify more clearly the responsibilities of physicians attending patients in these facilities.

Guidelines

These Guidelines, which were adopted by the AMA House of Delegates in December, 1977, are designed to clarify the role of attending physicians in long-term care facilities, to help them achieve high quality care for their patients and to assist them in working with the medical director in developing policies affecting patient care. They are intended to supplement the 1973 **Guidelines for a Medical Director in a Long-Term Care Facility** and to replace the earlier 1959 report. They should, of course, be taken as general suggestions only, and will need to be adapted to local conditions.

1. Each licensed physician admitting patients to the long-term care facility should observe its patient care policies, including those governing the provision of physician services if they do not conflict with accepted and established methods of care. The final decision on admitting privileges to the facility rests with the governing body.

2. Each physician seeking to admit a patient should obtain the administrator's consent.

3. It is important that each physician admitting patients provide such information as may be necessary to assure the protection of other patients and the facility's administration from those patient who are or may become a source of danger.

4. Each attending physician should designate an alternate phy

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sician or should advise his physician exchange of who may be called to see his patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the medical director shall have the authority to call another physician for appropriate treatment or treat the patient himself.

5. Prior to or upon admission of a patient, it would be desirable for the attending physician to perform a physical examination of his patient and provide the facility with an admitting diagnosis, statement of patient's functional status and orders for diet, medication and initial treatment. Other patient information required by the facility may be provided at the time of admission or as soon as practical thereafter and should include a family history, past medical history, report of current medical findings and a statement of rehabilitation potential and prognosis.

The physician should also make arrangements for furnishing the facility with appropriate laboratory, X-ray and consultation reports.

6. Each attending physician is responsible for planning the medical care of his patient. Upon admission of his patient, the physician should make a medical evaluation of his patient's immediate and long-term care needs. This should include information about medications, treatments, rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and, when appropriate, discharge. In developing this plan, it may be necessary for the attending physician to consult with the patient and/or the patient's family. The attending physician should review this plan at least annually and make revisions when appropriate. The plan may be reviewed by the medical director so that he may ensure consistency with the facility's policies.


7. The facility should inform each attending physician of the

availability of social, psychological and other nonmedical aspects of care for his patient so that he may assure himself that such care is compatible with the medical condition of the patient.

8. The attending physician should be aware of the need for the medical director, in fulfilling his required duties, to review the records of patients in the facility and, on occasion, actually contact the patient and/or family.

9. It is desirable for the attending physician to consult with the medical director and/or administrator when, in the judgment of either, there is a question as to the appropriate placement or the advisability of transfer of any patient originally admitted by the attending physician.

10. Where possible, the physician should reserve the right to seek consultation. As part of the treatment plan, this should be discussed with the patient. The facility's administrative personnel, medical director and other involved personnel, should not independently request consultation without



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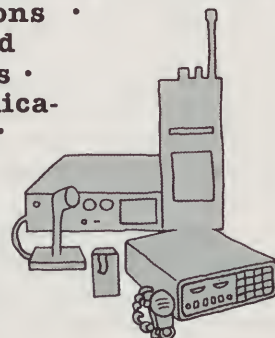
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prior approval of the attending physician.

11. The attending physician should visit his patient on a schedule determined by the patient's medical needs, and which is consistent with any state or Federal regulations applicable, and this schedule should be documented in the patient's record. The attending physician may review his schedule of visits for each patient in conjunction with an annual reevaluation of the patient's health status.

12. During each visit, the attending physician should see his patient, sign all written changes in orders, and enter a progress note in the patient's record indicating that the patient has been visited. It should be the duty of the charge nurse to call the attention of the attending physician to orders requiring renewal. Except as specifically indicated below, treatment orders should not be permitted to expire without notification to the attending physician.

13. The attending physician should give all orders for treatment in writing. An order may be considered in writing if it is dictated to a licensed nurse, signed and dated by the nurse, and countersigned by the physician at the time of his next visit to the facility or by other acceptable arrangements.

14. The attending physician and the charge nurse should review the patient's medications and other treatment orders at the time of visits. If there are no changes in the orders, the physician need only write that the orders be continued; however, this privilege of a simple note may be limited by facility policy.

15. Patients should be discharged only on orders of the attending physician, except that in an emergency situation the medical director may order a transfer to a hospital. After discharge, the attending physician should furnish the necessary information on the transfer form, and should complete and sign the patient's records as soon as practical. If the patient is to be transferred, the attending physician may, except in an emergency,

furnish the necessary information on the transfer form.

16. The attending physician should recognize that all orders for narcotics, sedatives and hypnotics, anticoagulants and antibiotics will be automatically controlled by institution policy unless the order specifies the number of doses to be administered, and the duration of time is specified.

17. The attending physician should be aware that the pharmacist may review the drug regimen of each patient and report his comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician.

18. It would be desirable for each attending physician to prepare and maintain a complete medical record for each patient.

19. It would be desirable for each attending physician to participate in developing and maintaining an appropriate quality assurance program for the facility. Such participation may extend to medical care evaluation studies and periodic assessments and evaluation of patient care.

20. The attending physician should recognize that all records are the property of the facility and may not be removed without permission. In case of readmission of a patient, all previous records should be available for the use of the attending physician. This should apply whether the patient is attended by the same or by another physician.

21. The attending physician should have free access to all medical records of all patients in the facility for bona fide study and research, consistent with preserving the confidentiality of information concerning individual patients and physicians. Physicians formerly having patients in the facility should be permitted free access to information from the medical records of their patients covering all periods during which the physicians attended such patient.

23. The attending physician may attend an annual meeting if appropriate at which the medical director, the administrator and the committees functioning in the facility shall make appropriate reports. Each attending physician should have the opportunity to make recommendations concerning the facility's staff, services and resources. ☐

Booklet Available

The Faculty's booklet, **Laws, Rules and Regulations With Which Physicians Must Comply**, may be sent free of charge to physicians upon request, and also to others related to the health profession, such as nurses, psychologists, hospitals, HMOs, etc. For those individuals or organizations unrelated to the health profession, such as lawyers, corporations, etc., the charge is \$10 per copy, plus \$1 for postage and handling. Payment must be sent with request to Med-Chi, 1211 Cathedral St., Balto., MD 21201. ☐

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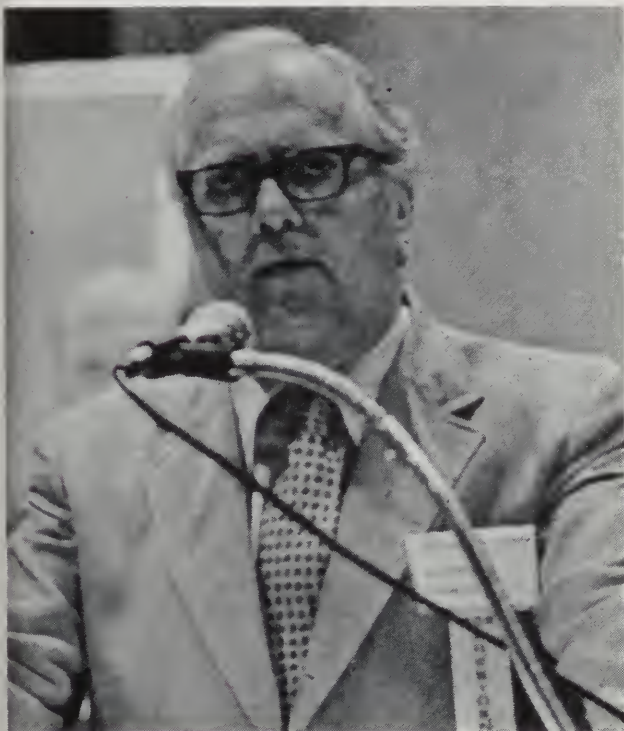
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Medical Miscellany

Consultation: Physicians on Radio

A biweekly radio program called *Consultation* on WBJC-FM (91.5 mc) currently features physician speakers suggested by the Faculty Public Relations Committee. The program, which began Nov. 15, 1978, came as a result of a need to fill the 6:30 PM Wednesday time slot immediately following WBJC's award-winning *All Things Considered* program. The Faculty was contacted and the first programs began almost immediately. On alternate Wednesdays, speakers appear on behalf of the Maryland Bar Association. Both the Faculty and the Bar Association make a minimal financial contribution toward each program. Interest in the hour-and-a-half program, which features a call-in format, has been lively. The program host is John Stupak. The following is a list of possible programs and guests to be featured over the next several weeks:

Slipped Discs, Edward Layne, MD; *Arthritis*, Mary Betty Stevens, MD; *The Common Cold and Other Problems*, Timothy Herbert, MD and Edward Kowalewski, MD; *Hypertension/Blood Pressure*, Albert Antlitz, MD; *Fear of Dentistry*, Irving Hawkins, DDS and Morris Roseman, Ph.D; *Diets/Nutrician*, Maria Simonson, MD; *Adolescence*, Richard Sarles, MD; *Pain*, Donlin Long, MD; *Sports/Medicine*, Kenneth Spence, MD; *Shock Trauma Unit*, R Adams Cowley, MD; *Ulcers*,



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Vernon Smith, MD; *Alcoholism*, Maxwell Weisman, MD; *Artificial Joints*, David S. Hungerford, MD and *Medical Education*, Richard Ross, MD and John Dennis, MD. □

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Doctors Take Note: Upcoming Meeting

June 4-8, 2nd. Anl. Diag. Rad. Sem., Marriott Motor Hotel, Phila., PA. Contact: Dr. Troupin, Hosp. of the Univ. of PA, Dept. of Rad., 3400 Spruce St., Phila., PA 19104. Cat. 1-34 hours. □

Rehabilitation Medicine

FREDERICK J. BALSAM, MD Editor

Rehabilitation of the Stroke Patient

By B. STANLEY COHEN, MD

•
Dr. Cohen is Chief of the Department of Rehabilitation Medicine at Sinai Hospital of Baltimore, and is also Professor of Rehabilitation Medicine at the University of Maryland School of Medicine. He can be contacted at Sinai Hospital for reprint and other data.

•
The ultimate goal of rehabilitation is the restoration of function. Ideally, the rehabilitated stroke patient should manifest mobility, independence in the performance of activities of daily living, satisfactory communication abilities and the capacity to return to family, recreational and vocational activities. The achievement of these goals will depend on a combination of factors, some inherent in the characteristics of the disease process, its nature, location and extent; some dependent on the premorbid personality, strengths and weaknesses of the person who has experienced the cerebral insult and many related to factors external to the patient. These latter include the support system within the family and community, as well as the promptness and adequacy of the treatment and rehabilitation programs. It is to this latter issue that the comments which follow are directed.

It is well-recognized at this time that the prognosis for ultimate function is related, in inverse fashion, to the time interval between the acute episode and the beginning of a restorative program. It has also been frequently demonstrated that in many instances failure to reach maximum function, and in some instances the ability to remain in the community, results as much from the dysmobility due to the complications of inadequate after-care as to the neurological deficit itself.¹

Examples of such complications are deconditioning, joint contractures, decubiti and peripheral nerve injuries, as well as psychological factors of depression, dependency and mental deterioration.

In all cases, planning for long-term management should begin concurrently with acute medical management. Skin care, with frequent turning to prevent

decubiti, proper positioning and support to prevent contractures and deformity, and careful handling to prevent joint subluxation and stretch or pressure neuropathies should begin at once. Prolonged positioning on the involved side may result in peripheral neuropathy. Traction on the paretic arm in moving and transferring the patient may result in brachial plexus injury or shoulder subluxation. Administration of intravenous fluids in the paralyzed arm may result in edema and restriction of joint motion.

Once the vital signs are stable and the patient is conscious, definitive rehabilitation measures should begin, in most cases within a day or two after onset. Careful neurologic and functional examination, of course, must precede the beginning of physical restoration. The deficits and the residual abilities are catalogued. The treatment plan is developed and short-term and long-term goals are established. These goals are reassessed at regular intervals. In most stroke patients, a team of many health disciplines is in order. The physician, nurse, physical therapist and occupational therapist are the most frequent team members. In most instances, the social worker and psychologist are also involved. Where speech and language problems manifest, the speech pathologist is a member of the team; later on, the vocational specialist may be appropriate.

Where significant visual field disturbance is present, the patient and bed should be positioned so that the uninvolved side faces away from the wall and toward the activity. Persons with homonymous hemianopsia who are placed in such manner that activity occurs on and they are regularly approached from, the "blind side," may become confused and agitated. The simple expedient of reorienting position may instantly correct an apparent dementia. In the case of the aphasic person, early efforts at establishing communication should be undertaken. In the absence of significant receptive aphasia, a communication board should be set up, using pictures or words as appropriate, so that the patient can indicate basic needs and feelings. Apparent incontinence can often be corrected by helping the aphasic to indicate the need for bed pan or urinal.

Physical restoration begins with positioning and performance of joint range of motion. The uninvolved side should receive exercise, both to prevent atrophy and weakness through disuse, and to develop the strength and coordination which will be required if, as in the majority of cases, full function is not regained in the involved extremities. If the patient is conscious and alert, he can be taught to carry the joints through the range of motion. If he cannot, the nurse and family can carry out these measures between therapy sessions. Sitting balance and sitting tolerance are established as soon as medically-feasible and transfer activities are begun. The patient is taught how to transfer with safety from bed to chair and from chair to toilet or commode. It is now well-established that less energy is consumed in use of a bedside commode than a bed pan. When sitting and standing, voluntary voiding is more easily-accomplished. External urinary collecting device may be used if frequency and urgency require them. Prolonged catheterization is rarely required.

Correction:

In the **Rehabilitation Medicine** section of the January, 1979 issue of the **Journal**, the name of **Frederick J. Balsam, MD**, as Editor of the **Rehabilitation Medicine Section** was inadvertently omitted from the logo. The **Journal** regrets the omission.

At the same time, the ability of the patient to perform or assist in activities of daily living (ADL) is assessed. These include toileting, bathing, grooming, dressing and feeding activities. One-handed activities, with the use of assistive devices, are taught. Where the dominant hand has been affected and prompt return of function has not occurred, change of dominance is taught.

Once adequate sitting balance is established and transfers can be accomplished, standing activities are begun. Frequently, parallel bars are used to provide stability with progression to ambulation with a walker or cane. The vast majority of stroke patients become ambulatory. In many, the short leg brace may be necessary to assist in clearing the foot and in stabilizing the ankle. Occasionally, a long leg brace is required for knee stabilization.

Exercises to restore function in the involved extremities are performed in stepwise fashion. Various techniques have been described and are preferred by different therapists in accordance with their training and experience. The critical issue is whether they can be integrated into functional activities. Prolonged performance of activities which can be accomplished only with the therapist and are not made part of daily activities within weeks or at most a few months is probably not justified. Stepwise progress, with an expectation of significant improvement, justifies continued therapy until a plateau in function is approached.

During the course of treatment, the pattern of psychological response is assessed and, with it, the need for intervention. Psychological denial is to be expected early in the course of the illness. Next, there is recognition of loss of function, mourning of the loss with a degree of reactive depression, and, then, adjustment to the disability and participation in the rehabilitation program in order to maximize function. The persistence of denial or the failure to deal with depression suggests the need for professional psychological support and therapy. In addition to psychological denial, there may be neurological denial. Particularly where there is substantial non-dominant hemisphere involvement, the patient may have major perceptual deficits and may deny the involved part to the extent of failure to bathe, shave, use makeup on, or dress the involved side. In severe cases, denial of the illness itself may result. Perceptual disorders may represent a significant impediment to therapy and require retraining. Visual-spatial deficits interfere with self-care and ambulation. The perception of verticality may be altered and require balance training in order to reorient the patient as to his position in space and the relative positions of his body parts.

There may be organic involvement of cognition, memory deficits, loss of abstract thinking and personality change. Where severe, these will interfere with physical rehabilitation and prevent vocational rehabilitation. Persons with mild to moderate involvement, however, can function satisfactorily and many can be trained for vocational activity.

The prognosis for functional activity is dependent

on age and medical factors. Frequently, prognosis is not dependent on motor return alone.²⁻³ Among the factors of importance in limiting function are severe sensory deficits, including visual, severe perceptual problems and the presence of such complications as contractures, often related to the length of time from onset to entry into the treatment program. The prognosis for return to vocational activity has been carefully studied and has been tied to various psychosocial and economic factors. For example, educational background, vocational attainment prior to illness and the presence or absence of disability compensation benefits have been found to be as important as the degree of residual muscle weakness in vocational success after stroke.⁴

Summary

In summary, it should be noted that the prognosis for physical recovery in survivors is better than previously believed. Early and adequate rehabilitation measures, with prevention of complications, will result in the ability to ambulate alone and ADL independence in 60-80%. An additional 10-25% can be expected to ambulate with assistance and perform activities of daily living with assistance. The ability to perform in competitive employment or in homemaking activities can be expected in 45-50%, with an additional 10-15% functioning in a sheltered work setting.

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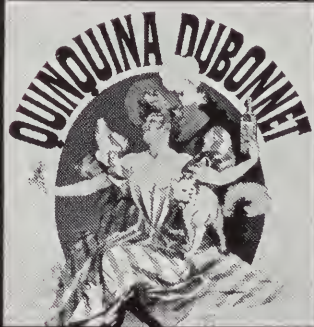
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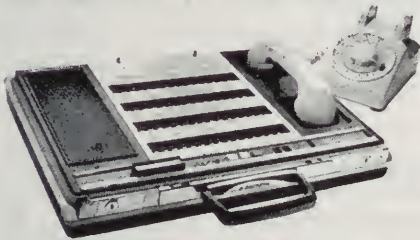
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May 25, Trtmt.-Resistant Depression, 1-5:15 PM, talk by spkrs. Jan Fawcett, MD and David Kupfer, MD for four hrs. CME cred.

June 6, Transvestism, 8-10 PM, talk by Tom Wise, MD for 10 hrs. CME cred.

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All classes, talks, etc. held in Rm. 101, Ross Hall, GWU Sch. of Med. and Health Sci., 2300 I St., NW, Wash., DC. For details, call Dr. Arthur St. Andre at (202) 676-2821. All talks on Weds. evenings, 6:30-8:30.

May 16, Rheumatology II, talk by Robt. Jacobs, MD, 6:30 PM.

May 23, Endocrinology I, talk by Kenneth Becker, MD, 6:30-8:30 PM.

May 30, Endo. II, talk by Dr. Becker, same times as above.

June 6, Renal: Acid-Base, Water Metabolism, talk by Robt. Shalhoub, MD, 6:30 PM, and **Glomerular Diseases (Calculous)** at 7:30 PM.

June 13, Renal: Tubular Dis. incl. Acute Renal Failure, talk by Anne Thompson, MD, at 6:30, followed by **Chronic Renal Failure, Transplantation**, at 7:30 PM.

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For details, contact Frank J. Ayd, Jr., MD, Taylor Manor Hosp., Ellicott City, MD 21043, or call (301) 465-3322.

May 23, Childhood Depression, talk by Leon Cytryn, MD, 3 PM, in Psych. Ctr.

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May 11-12, Rehab. of Patients With Stroke or Hip Fracture. For details, call (301) 528-3956.

May 18-19, Problems in Embryonic and Early Fetal Development. For details, call number above.

June 3-9, 5th Anl. Family Med. Review. For details, call above number.

June 15-16, Symposium on Head and Neck Carcinomas. For more data, call above number.

June 21-23, Dermatology Days. Call above number for details.

Other Maryland Meetings

April 27-28, Sexuality and the Cardiovascular Patient, Cross Keys Inn, Balto., co-sponsored by Amer. Heart Assn. Council on Clin. Cardiology; Amer. Heart Assn.-MD Affiliate; Amer. Heart Assn.-Central MD Chap. Accred. AMA, Amer. Acad. of Fam. Prac., Amer. Assn. of Crit. Care Nurses. For further Information, contact Mrs. Michaeline Silverstein, Prog. Dir., Amer. Heart Assn.-Central MD Chap., PO Box 17025, Balto. MD, 21203; (301) 685-7074.

May 2, Pain Management talk by Vinod K. Bhalla, MD. For details, call Ms. Karen Lane at (301) 821-5222.

Miscellaneous Meetings

May 2-5, Anl. Mtg. of VA Soc. of Ophthal. and Otolaryn., Inc.,

Boar's Head Inn, Charlottesville, VA. For details, write R.E. Gardner, MD, Staunton Med. Ctr., Staunton, VA 24401.

May 12-15, 213th Anl. Mtg. of Med. Soc. of NJ, Convention Hall, Atlantic City, NJ. For details, call Mrs. Marion R. Walton at (609) 896-1766.

May 23, Delaware Reg. Mt., Amer. Coll. of Physicians, Delaware Acad. of Med., Wilmington, DE. For info.: Robt. W. Frelick, FACP, Suite 28, Prof. Bldg. Augustine Cut-Off, Wilmington, DE 19803.

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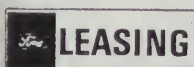
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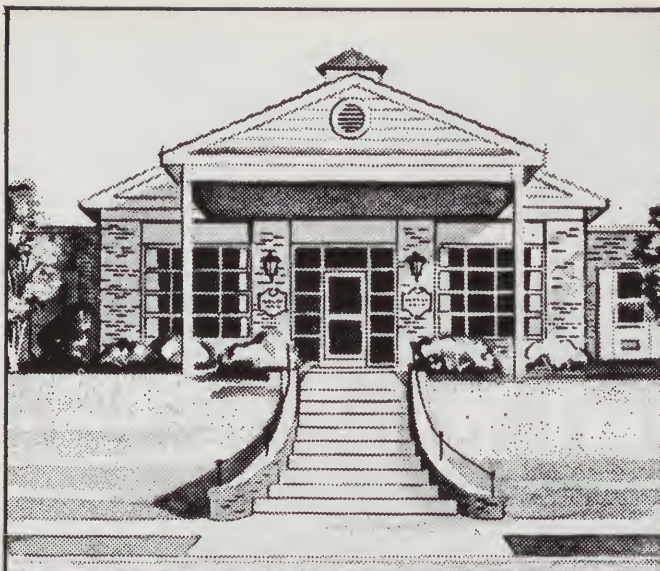


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Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

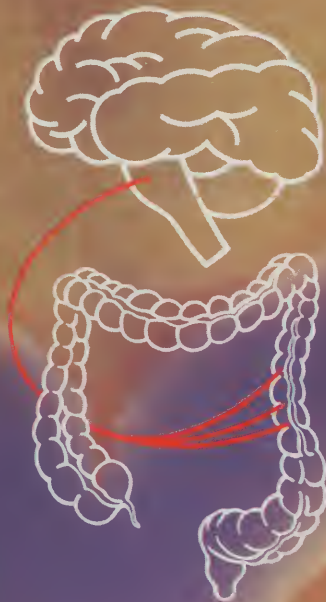
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



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The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.

However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).



Motrin[®] 400 mg TABLETS ibuprofen, Upjohn

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one more reason to prescribe Motrin.

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J-6857-4

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Motrin[®] 400 mg TABLETS

ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss pregnancy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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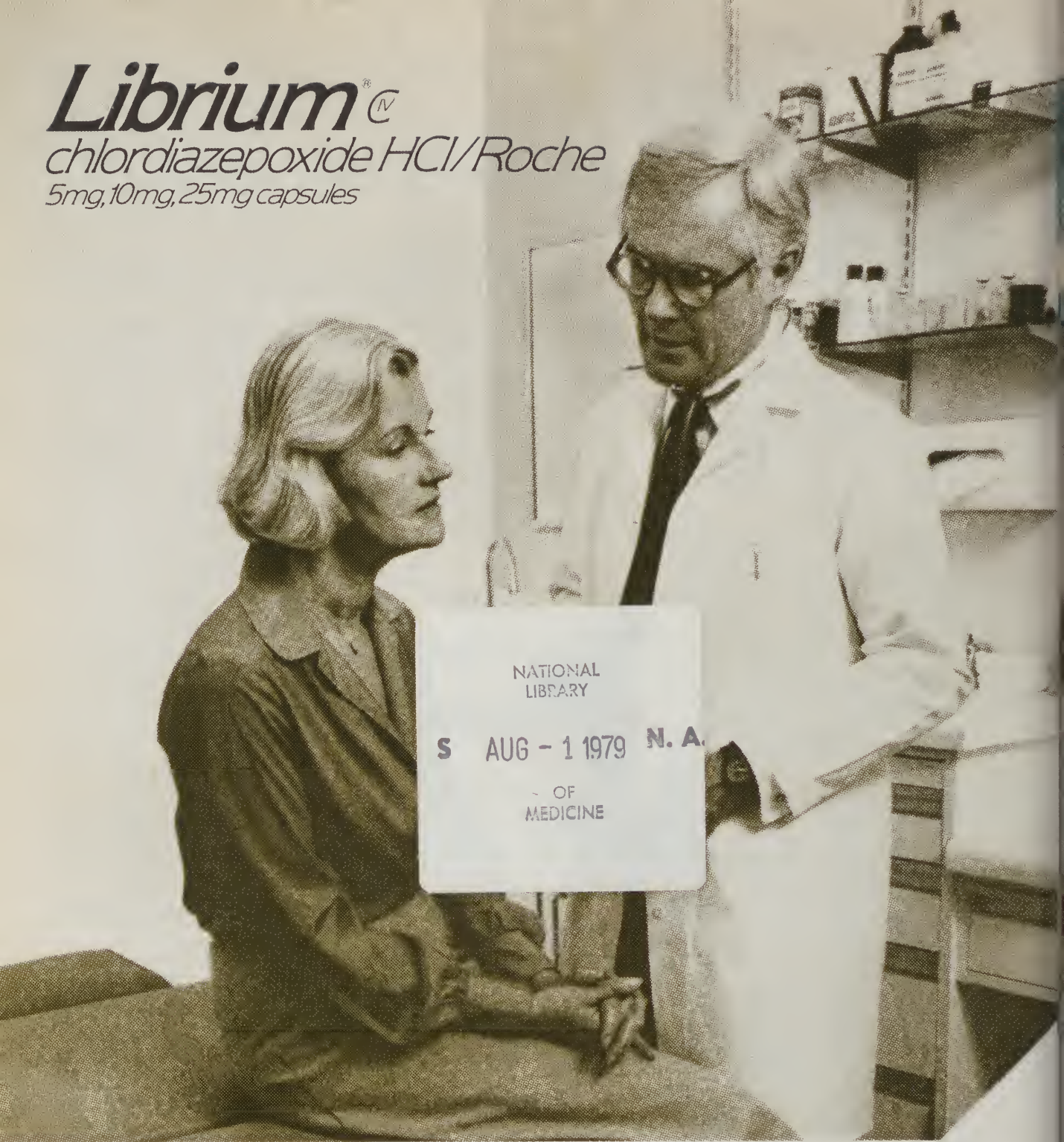
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*Jesse C. Coggins Memorial Building
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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



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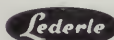
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Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N. Y. 1969.



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Class postage paid at Baltimore, MD.
Accepted at the special rate au-
thorized. Published monthly.
Subscription rates: US, US Pos-
sessions, one year \$8; elsewhere
\$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily
reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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Dr. Jesse C. Coggins; story on page
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anxiolytics may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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The Open Forum

"Competent Historical Research . . ." Was Prince Eddy Dyslexic?

To the Editor:

Blaine Taylor's lucid account of the life of "Prince Eddy," alias Jack the Ripper (*Health in History: Was Jack the Ripper Heir to the British Throne? A New Book Says "Yes!"*—February, 1979—ed. note) is a well-documented example of competent historical research.

Nevertheless, what still remains to be resolved is the nature of the Prince's severe mental retardation. He was said to be, "The dimmest of all the children," was "Incapable of learning," was considered to be "Extraordinarily backward" and was described, as behaving as if, "He had a weakness of the brain;" however, despite his alleged imbecility, the Prince was said to be "a pleasing young fellow," who was "natural and unstuck-up," "extremely polite in his manner," as well as being "modest, equable and deferential to his elders," particularly to his grandmother, Queen Victoria, who "regarded him with affection."

Furthermore, the Prince became "moderately efficient" while in military service, took "great interest in his uniform" and "dressed himself with utmost care." Indeed, he was reported as being "almost smart to the

point of dandyism" and was nicknamed "Collar and Cuffs." Prince Eddy also was a notorious womanizer, which appears to be at odds with his "backwardness."

There is the possibility that his boredom and early deviate behavior may have been due to a specific reading disability (dyslexia), which would have made it impossible for him to learn to read and, therefore, he could be thought of as being severely-mentally retarded by his teachers and family.

Dyslexia occurs six times as often in boys as in girls, and usually there is a family history of slowness in learning to read. The existence of poorly-established handedness in these cases would indicate that there exists a disturbance in the normal development of the brain, with a resulting right-left disorientation in space. These children cannot read consistently from left to right, and require special remedial reading. Many dyslexic children frequently respond to being called "stupid" by their peers and family with socially-deviate behavior.

The possibility that the Prince may have had dyslexia is not being offered as even being a partial explanation of his Jack the Ripper activities. From a psychiatric point of view, the diagnoses of syphilis and homosexuality also cannot be used to "explain" a compulsion to disembowel women.

Prince Eddy's case is rare in the annals of crime.

Guttmacher has stated, that "Pure sadistic homicides, the so-called lust murders, are fortunately rare." Those who commit this type of murder are "mostly sexually impotent, and nearly all are psychotic—without exception." Homocidal, psychotic murderers also have been treated cruelly in early life, "have formed a lasting, blighting identification with brutal parents" and "have learned that violence was a solution to frustration." (Reference: M. Guttmacher, *The Mind of the Murderer*, NY, Grove Press Inc., 1962, p. 95-96.)

It may be worthwhile to try to establish the diagnosis of dyslexia in the case of Prince Eddy, as it would help to explain his alleged, apparent, mentally-defective behavior.

JACOB H. CONN, MD

Diplomate, American Boards of
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Concerning Timoptic . . .

To the Editor:

I want to mention to your readers the possible systemic complications with the use of the new anti-glaucoma eyedrop—TIMOPTIC (Timolol, Merck, Sharp and Dohme).

This medication has become available for general ophthalmic use since November, 1978, and because it does not have the usual side-effects of the standard glaucoma drops, it is likely to be very widely-prescribed by ophthalmologists. I began working with the drug some two years ago during a glaucoma fellowship, and so have had more time to see or learn of significant systemic and local reactions. These adverse reactions are referred to in the package insert, but the patient's general physician is perhaps not likely to be familiar with this ophthalmic drug.

Timoptic is a beta-adrenergic blocking agent and there is significant systemic absorption when it is used in the eye in the recommended dosage. Patients with asthma can have their condition worsened or have an acute attack precipitated by the use of Timoptic. Furthermore, patients can experience marked bradycardia and a fall in blood pressure. Although these complications are uncommon, I did want to remind my colleagues that they can occur.

RONALD C. RICHTER, MD
14 W. Coldspring Lane
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PAUL SNOW, MD
Dept. of Laboratories
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Cumberland, MD 21502.

On Carcinoma

To the Editor:

I read with interest the article by Dr. Neil Novin in the February, 1979 issue of the *Journal* concerning carcinoma in a 19-year-old male. Approximately six years ago, I saw a similar case when working in Northern Virginia. I gathered numerous references in hopes of publishing the report, but never got around to doing so.

Following are the references:

Owens, Mark P., Maj, M.C.: Cancer of the Colon in the Young Adult, *Ann. of Surg.*, V. 174, July, 1971.

Kern, W. H., Capt. MC, AUS and White, William C. MD: Adenocarcinoma of the Colon in a Nine-Months-Old Infant, *Cancer*, July-August, 1958.

Ferguson, Emmet, Jr., MD, FACS and Obi, Lewis J., MD: Carcinoma of the Colon and Rectum in Patients Up to 25 Years of Age, *The Amer. Surgeon*, April, 1971.

Kottmeier, Peter K., MD and Clatworthy, H. W., Jr., MD: Intestinal Polyps and Associated Carcinoma in Childhood, *Amer. J. of Surg.*, Vol. 110, November, 1965.

Carrington, W., Jr. MD: Carcinoma of the Colon in Childhood, *Annals of Surg.*, 139: 816-25.

Sessions, R.T., MD; Riddell, D.H., MD; Kaplan, H.J., MD and Foster, J.H., MD: Carcinoma of the Colon in the First Two Decades of Life, *Ann. of Surg.*, August, 1965.

van Langenberg, Arthur, G.B. OnG.: Carcinoma of Large Bowel in the Young, *Brit. Med. J.*, 1972, 3, 374-376.

Pissiotis, C.A., MD; Gulesserian, H.P., MD and Condon, R.E., MD: Colorectal Carcinoma in the First 25 Years of Life. *J. of Surg. Onc.*, 87, 1974.



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Doctors in the News

Hopkins Hospital Director Testifies Against Administration's Cost Containment Bill

The Director of the Johns Hopkins Hospital testified against the Administration's hospital cost containment bill recently. **Robert M. Heyssel, MD**, who is also President of the Council of Teaching Hospitals, told the US House Ways and Means Subcommittee on Health that Hopkins' record in containing costs would have been hampered by provisions like those in the new bill.

Particularly critical of the wage increase pass-through for non-supervisory employees allowed in the bill, Dr. Heyssel told the Subcommittee costs will be impossible to control if non-supervisory workers feel a hospital can increase wages with no real penalty. "In a labor-intensive industry, if you exempt salaries, you won't control anything," he stressed.

During the last fiscal year, the Hopkins Hospital inflation rate per admission was 8.2%, Dr. Heyssel said. Hopkins, however, was operating under the regulations of the Maryland Health Services Cost Review Commission (HSCRC), which does not allow a wage pass-through. Hopkins non-supervisory workers, therefore, realized that they had to accept a new contract within the Commission's 7% allowable increase for inflation, he said.

Dr. Heyssel contradicted prior Administration testimony that non-supervisory workers in hospitals are paid less than persons in similar positions in industry. Data developed by the Maryland HSCRC shows this is no longer true, he said. In fact, the HSCRC found that hospitals in Baltimore were paying many of its non-supervisory workers more than they would earn in industry doing comparable jobs. For instance, unskilled and clerical workers were paid, on the average, 18.4% above those in industry in similar job classifications.

According to Dr. Heyssel, the 1% increase allowed by the Administration for service and program improvements would drastically curb new technology.

"Since 1950, Social Security Administration analysis has repeatedly shown that approximately one-half of the increase in hospital costs has been a result of improvements in hospital services," Dr. Heyssel noted. "I don't believe the American public wishes dramatically to curtail improvements in hospital service," he stressed.

Dr. Heyssel emphasized that Johns Hopkins could not have opened its new Comprehensive Cancer Center in 1977 if the HSCRC had not allowed Hopkins temporarily to exclude the Center's costs from the Hospital's total inflation rate. The Administration's proposal would "close the system and freeze us and the public where we are now in the treatment of disease," Dr. Heyssel declared.

Dr. Heyssel offered to the Subcommittee some of his own recommendations for curbing hospital costs. These include:

- Fully implementing the PSRO and health planning mechanisms; extending PSROs to all patients regardless of payer, and requiring community physicians to comply with the same regulations for new facilities and equipment as are applied to hospitals.

- Allowing Medicare and Medicaid to pay State-determined rates.

- Requiring cost impact statements for regulations and legislation affecting hospitals.

- Recognizing that comparative, prospectively-determined rates are a legitimate way of containing costs.

- Allowing the true voluntary effort of American hospitals to continue.

"No one should be deceived into believing that the Administration's bill combines a voluntary cost con-

tainment program with a mandatory program," Dr. Heyssel said. "Both cost containment sections are mandatory, because the Secretary sets the limits on each. There is a truly voluntary program that is working now, and that program should continue."

The Council of Teaching Hospitals, which Dr. Heyssel heads, represents over 400 major teaching hospitals. These hospitals provide the most complex tertiary services and are responsible for a majority of the nation's graduate medical education programs. □

Dr. Robert Austrian Gives Hopkins' Thayer Lecture

Dr. Robert Austrian, Chairman of the Department of Research Medicine at the University of Pennsylvania and co-winner of the 1978 Albert Lasker Clinical Research Award, presented this year's Thayer Lecture at the Johns Hopkins School of Medicine. He recently discussed "The Pneumococcus at Hopkins: Early Portents of Future Developments."

Dr. Austrian was awarded the Lasker prize for developing a vaccine that could prevent three-quarters of the nation's estimated 750,000 annual cases of pneumococcal pneumonia.

A 1941 graduate of the Johns Hopkins School of Medicine, Dr. Austrian began his research with pneumococci while on the Hopkins faculty, where he was an instructor in medicine from 1942-52. A native Baltimorean, he also received his BA from Hopkins and was a university trustee for six years. Dr. Austrian's father, **Dr. Charles Austrian**, was a distinguished Hopkins physician. His mother, Florence H. Austrian, is a noted Baltimore artist.

In 1970, Dr. Austrian received the Distinguished Alumni Award and, last year, was chosen for membership in the Johns Hopkins University Society of Scholars.

The Thayer Lectureship was endowed in the memory of Dr. William Sidney Thayer, a former professor of medicine at Hopkins, and his wife, Susan Read Thayer. The lecturers are scholars distinguished in clinical medicine, pediatrics, neurology or related disciplines. □

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Executive Committee

The Executive Committee met on March 29, 1979 and took the following actions:

1. Approved a contribution of \$300 towards costs of presenting a mock health claims arbitration panel on Thursday, June 7, 1979, from 7 PM to 10 PM at the University of Maryland School of Medicine.
2. Approved a contribution of \$500 towards the cost of transportation of a visiting mainland China physician who would be in the area early in May, 1979. This will be a cosponsorship of a meeting with the Baltimore City Medical Society, at which a scientific program will be presented.
3. Authorized expenditure of up to \$1,500 for the cost of honoraria for speakers at the 1979 Semiannual Scientific meeting being held in New Orleans, LA.
4. Authorized the immediate Past President to serve in an official liaison capacity with the Maryland Hospital Association.
5. Provided the Maryland Scholarship Board with a list of family physicians, three of whom will be selected to serve as an advisory group in connection with the Family Practice/Residency and Family Practice Medical School scholarships.
6. Designated Edmond J. McDonnell, MD of Baltimore to be reappointed to the Advisory Council on Hospital Licensing. □

Council

The Council met on March 29, 1979 and took the following actions:

1. Approved recommendations to the House of Delegates for various members, all on the request of the Component Society concerned.
2. Waived 1979 dues for various members on account of illness, all at the request of component societies involved.
3. Approved the following resolution, at the request of the Faculty Committee on Continuing Medical Education:

"Whereas, Standards for accreditation of Continuing Medical Education in Maryland were the result of an agreement between the American Medical Association and the Medical and Chirurgical Faculty of the State of Maryland in 1972 and

Whereas, The Committee on Continuing Medical

Education of the Medical and Chirurgical Faculty of the State of Maryland was the recognized body delegated the responsibility of overseeing continuing medical education activities in the State of Maryland and

Whereas, This aforementioned Committee continues to function as the only organization in Maryland delegated the authority to review institutions and organizations in order to ascertain their qualifications for accreditation for continuing medical education and

Whereas, This same Committee gives consultation and guidance to organizations and institutions in the state who have applied for accreditation as well as those already accredited and

Whereas, An intolerable delay in the accreditation process has occurred since this authority passed from the American Medical Association to the Liaison Committee on Continuing Medical Education (LCCME) and

Whereas, The Liaison Committee on Continuing Medical Education has drawn nationwide criticism for failing to keep the state Continuing Medical Education Committee currently well-informed and

Whereas, Many state Continuing Medical Education committees have joined, out of frustration and/or concern, the National Council of State Committees on Continuing Medical Education and

Whereas, the Maryland State Board of Medical Examiners does not recognize the AMA's Physician's Recognition Award as a valid instrument for the purpose of reregistration of license to practice medicine in the state of Maryland therefore be it

RESOLVED, That the Medical and Chirurgical Faculty of the State of Maryland reaffirm the concept of accreditation of Continuing Medical Education by those state medical associations whose standards for Continuing Medical Education are in agreement with those established by the AMA and the Liaison Committee on Continuing Medical Education and be it further

RESOLVED, That the Medical and Chirurgical Faculty of the State of Maryland instruct its delegates to the AMA to support the principle that the LCCME permit those state medical associations whose standards are in agreement with the AMA and the LCCME to once again accredit institutions and organizations within their jurisdiction for Continuing Medical Education and be it further

RESOLVED, That failing such an agreement, the Medical and Chirurgical Faculty of the State of Maryland cease recognition of the LCCME as accrediting authority for Continuing Medical Education in the state of Maryland and concern itself with the Continuing Medical Education needs of the physicians of the state as mandated by the Maryland State Board of Medical Examiners and be it further

RESOLVED, That a copy of this resolution be sent to the CME Committee of each state, district and territory with the recommendation that they consider and support similar action in their state".

4. Declined to appropriate \$5,000 for assistance to medical students in underwriting continuing study during summer months in a clinical situation. Suggested that funds for this be taken from the contributions made through Faculty members on an annual basis to both medical schools, which are unrestricted in their use.

5. Declined to participate to the extent of \$9,000 in a proposed study dealing with primary care services rendered by physicians in Baltimore City. Indicated that this would establish a dangerous precedent and require the Faculty to contribute to similar studies by other components, and also indicated its feeling that this was properly a funding responsibility of the Federal or State government, inasmuch as this data is needed by the HSAs.

6. Heard that the case of Hartsock vs. the Faculty has been dismissed by the Court.

7. Endorsed project **Survival Guide**, which is to be published as part of the Baltimore City yellow pages of the telephone directory, after learning that content had been approved and recommendation made in this regard by the Faculty's Committee on Medical Emergency Services.

8. Approved Williamsburg, VA, as the site for the 1980 Semiannual Meeting, for the dates of Thursday, Sept. 11 through Sunday, Sept. 14, with the understanding that the House of Delegates sessions will be held in Baltimore. ☐

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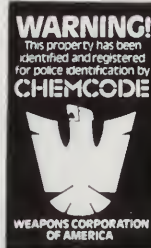


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Doctors in the News

"Harmless" Microorganisms Endanger Growing Number of Patients

A disease whose only known major outbreak before 1960 was among malnourished infants in Europe after World War II has replaced polio, scarlet fever, pertussis and diphtheria as a prominent concern of infectious disease specialists at the John Hopkins Children's Center. A form of pneumonia first reported in the United States in

1956, the disease is caused by a microorganism, *Pneumocystis carinii*, that infects without symptoms 70% of healthy children by four years of age, but causes illness only in those whose immune systems are suppressed by drugs or disease.

Ironically, the same medical techniques that have enabled more cancer patients, premature infants and organ transplant recipients to survive have increased the number of patients unable to resist normally "harmless" microorganisms such as

P. carinii, says Walter T. Hughes, MD, Director of the Division of Pediatric Infectious Diseases at Hopkins.

"It is likely that within the next few years we will see more patients with *P. carinii* pneumonia than with the so-called common childhood infections of measles, rubella and mumps," he predicts.

Control of *Pneumocystis pneumonia* is hampered by a lack of basic knowledge about the microorganism *P. carinii*. It is so poorly understood that microbiologists still aren't sure whether it is a protozoan or a fungus, and they can only guess at its mode of transmission point of entry into a person's system and natural habitat.

Another problem is diagnosis. Although doctors have found that the otherwise fatal disease can be effectively treated and prevented with the drug compound trimethoprim-sulfamethoxazole, they cannot easily confirm diagnosis without surgically removing a portion of a patient's lung for study.

Hopkins scientists are pursuing some promising leads, however. They know that many mammals from all continents, including cattle, sheep, goats, foxes, monkeys, swine, dogs, cats, rats and mice carry *P. carinii*. This knowledge has led to the development of an animal model to study the disease: all rats given drugs which suppress the immune system, such as those used to prevent rejection of transplanted organs, eventually become infected with *Pneumocystis pneumonia*, and most die. The knowledge that many pets probably carry *P. carinii* has suggested another area of study, the possibility of animal-to-man transmission.

An investigation of the link to protein-calorie malnutrition has also yielded useful information. Among a group of South African children with a form of malnutrition called Kwashiorkor disease, Dr. Hughes found that 7% became ill with *Pneumocystis pneumonia*—about the same prevalence as in patients whose immune system are

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Coming in the Journal:

Medicine in Maryland During the Civil War, by Douglas G. Carroll, Jr., MD (1915-77)

suppressed by drugs. This finding suggested that the malnutrition many cancer patients suffer, due to a lack of appetite, could make them more susceptible to infection.

Hopkins scientists are also hopeful that new laboratory techniques to identify the organism in the test tube will provide them with safer, faster and cheaper ways to diagnose *P. carinii* and other infectious diseases.

"While sophisticated medical technology has helped prolong the lives of patients with previously untreatable diseases, it has brought with it new problems, such as enabling formerly 'harmless' microorganisms to become virulent, but we are hopeful that this same technology will also be the means for their control," says Dr. Hughes.

"Combatting these new diseases will be one of the major challenges in coming years to infectious disease specialists in this country." □

Montgomery County Medical Society Presents Awards

The Montgomery County Medical Society recently gave awards to six citizens for their contributions to the health care of the community. The awards, in the form of certificates, were presented at the Medical Society's General Membership Meeting held at Indian Spring Country Club.

The awards were given to State Senator Margaret Schweinhaut for her long-standing interest in health care, particularly in aid of the elderly and the handicapped, during her 24 years in the State Legislature; to County Executive James P. Gleason for his efforts in the development of the Montgomery County Medical Center, drug abuse programs, a community crisis center and meeting health needs of the elderly, handicapped and youth with alcohol problems; to Mrs. Elizabeth L. Scull, County Council President, for her work with developing enabling County legislation to establish the Health Systems Agency, anti-smoking laws in public places and as Council member since 1970, many other health issues; to Herman A. Meyersburg, MD and George J. Cohen, MD for



MONTGOMERY COUNTY AWARD WINNERS were (left to right) **HERMAN A. MEYERSBURG, MD**; **CAPT. MARY BETH MICHOS, RN**; **SEN. MARGARET SCHWEINHAUT**, **COUNTY COUNCIL PRESIDENT ELIZABETH SCULL** and **GEORGE J. COHEN, MD**.
(Photo courtesy of the Montgomery County Medical Society.)

establishment and continuing work with Mobile Medical Clinics, which now offer services at Ken Gar, Holly Hall, Lincoln Park Community Center and Fenwick House and to Capt. Mary Beth Michos, RN, of Fire and Rescue Services on the Heart Mobile, the designing of the Mobile Intensive Care Units, train-

ing Paramedics and service on the County's Emergency Medical Services Council.

The presentations were made by **Allen J. O'Neill, MD**, President of the Medical Society and **DeWitt E. Delawter, MD**, Chairman of the Society's Special Awards Committee. □

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Executive Director's Newsletter

May, 1979

PHYSICIAN FROM
CHINA TO ADDRESS
MEETING

A special joint meeting of the Faculty and Baltimore City Medical Society is scheduled for Sunday, May 13, 1979, when Huang Chia-ssu, MD, will be the guest speaker. The session will be held at 7:30 PM at the Cross Keys Inn, Baltimore, in the White Oak Ballroom. Dr. Huang will address the guests on current medical education in China.

LEGISLATURE
ENDS

The General Assembly adjourned on Monday, April 9, at midnight, until the 1980 General Assembly convenes. During the summer months, innumerable studies will take place in areas of health and health-related services.

A complete listing of all bills introduced and the final disposition of them is available from the Faculty office.

NOTE: This will be mailed upon request from the Faculty office.

Despite efforts by the Faculty, a bill was enacted that would permit physical therapists to see patients directly and without referral from a physician. The Mental Hygiene laws were amended so that rather than only two physicians certifying patients for admission to mental institutions, it can be either two physicians or a clinical psychologist and a physician.

Heavy efforts by the Faculty and the Ophthalmologists resulted in defeat of a bill permitting Optometrists to use diagnostic medications. This was not accomplished without whole-hearted cooperation of all groups involved. The final vote was 15-7 in the House Environmental Matters Committee. The Senate Economics Affairs Committee voted approval of the bill to the Senate by a vote of 5-4. Copies of the voting list are available upon request.

A measure to include physicians' offices in the Certificate of Need program was defeated with the Faculty being the only group in opposition. Supporters of this measure included the State Health Planning Agency, Maryland Blue Cross, Maryland Hospital Association, Health Insurance Association of America and others.

A measure to place at least one consumer on health licensing boards within the Department of Health and Mental Hygiene was sent for summer study. Again, the Faculty was the only group appearing in opposition to this measure. As written, the Board of Medical Examiners would have been increased by the addition of two consumers, as would the Commission on Medical Discipline.

OTHER
LEGISLATIVE
MEASURES

A bill requiring hospitals to amend their bylaws to include privileges for Podiatrists was enacted. Another podiatry bill was enacted changing the definition to include the amputation of a toe or toes.

A bill that would have extended the number of terms a member could serve on the Health Services Cost Review Commission also passed the House but was retained in the Senate Finance Committee.

Maryland will become the first state where physicians and dentists will be required to identify themselves as specialists only through approval of the separate licensing agencies. Similar in nature, these laws will prohibit the advertising or "holding...out as a specialist" of either of these professions without prior approval of the Board. The acts take effect July 1, 1980. NOTE: This is IDENTIFICATION, not Certification.

MOCK
HEALTH CLAIMS

A mock Health Claims Arbitration Panel will be presented on Thursday, June 7, 1979, at the University of Maryland School of Medicine, Freshman Lecture Hall, starting at 7 PM.

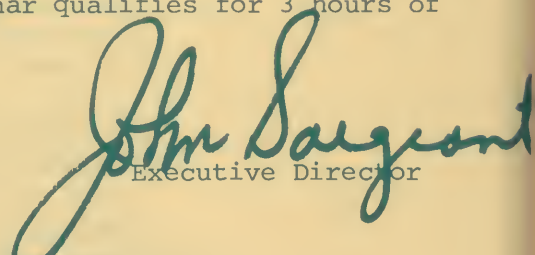
ARBITRATION

The seminar format will consist of the following:

PANEL

- | | |
|------|--|
| 7:00 | 1. Overview of Statute - through panel selection |
| 7:40 | 2. Pre-hearing procedures |
| | Total of 40 minutes |
| 7:40 | 3. Conduct of hearing |
| | 4. Decision-making process |
| 8:25 | 5. Post hearing procedures |
| | Total of 45 minutes |
| 8:25 | Break |
| 8:45 | |
| 8:45 | 6. Mock hearing - editor and lawyers |
| 9:30 | Total of 45 minutes |
| 9:30 | 7. Questions and answers - panel |
| | Total of 30 minutes |

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Executive Director

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"Peeking in" at Peking

Yes, our December, 1978 trip to Red China was fantastic! The timing was indeed fortuitous. The Chinese called us "the first delegation" from the United States to arrive after "normalization of relations" was announced—and we *really* got the "Red Carpet" treatment (the best hotels, well-heated; special treats and marvelous discussions we never dreamed possible there!)

The food was very good, including glazed meats and chicken with nuts, shark's fin soup, pressed duck and Peking Duck, glazed apples and almond milk—all prepared very differently from Chinese food here—and such "exotic" items as squid, octopus, snake and deboned duck's feet! There was fresh fruit and much jasmine tea between meals. Aside from a few colds, our sturdy group of radiologists all stayed well.

We had limited this trip to Hong Kong and Mainland China and were gone 18 days, flying over the Yukon and Alaska one way by day (which never ended as we flew with the sun).

Southern China was lush green and sub-tropical like Florida, while Northern China was white with snow, blustery and bleak in winter. It was fascinating to experience the picturesque contrasts of this vast country of an over 900 million population. Even the stature of the people is different, those in the North seeming larger and more Mongolian in appearance.

We visited schools, communes, factories, villages, old Emperor's palaces (now "the peoples' museums") and

temples in several cities (Canton, Foshan and Peking). We trod up and down the Great Wall, in the Ming Tombs and at the now-famous Poster Walls (or Democracy Wall) in Peking, snugly-layered in our thermal undies, boots and sweaters. We were fortunate, too, in being at the home of State Department friends our first night in Peking when the long Politburo meetings chanced to be concluded. Here we got a firsthand translation and interpretation of the important switches made in the ruling hierarchy and the changing political emphasis decided upon—down-playing future criticism of the "Gang of Four" and stressing modernization and normalization instead, full steam ahead. (Still, Mao's Mausoleum was barely mentioned as we viewed it in huge Tien An Men Square—in contrast to scheduled visits on all recent past itineraries. Mao's pictures and slogans still abound, but pictures of the foursome Marx, Engel, Lenin and Stalin are also around, although Russia is truly hated now.)

There were no limitations to our wandering on our own, so long as we kept our bearings, for the language barriers are great. A few Chinese words of greeting and farewell, thanks, mutual applause, and a smile went a long way, however, and we had wonderful walks down nameless narrow mazes of streets where "the people" live in the "real China."

Quarters are incredibly cramped and sparsely furnished, with a bare lightbulb per room, and one or two rooms per family. A ladder in the front room (or *only* room) leads to a loft for family sleeping, dormitory-style, on the floor—or sometimes mosquito-netted mattresses are at one side of the room, which serves as sitting room, dining room and bedroom. A bare metal spigot with running water serves the occupants of the street who do their wash, etc. outside, and there is a communal bathroom of sorts. Toilets do flush, but are without seats—even in railroad stations and airports! (Some trains have no restrooms and travelers use those at station stops!)

Indelible memories remain of peasants working with water buffalo in the irrigated fields, fishing the rivers from handrowed junks with huge nets, living in sampans or driving along the roads in heavily-overloaded horse-and-donkey-drawn wagons, pedicabs and the strangest vehicles rigged up to run! The congested bike traffic everywhere made us grateful they weren't cars!

With rare exception, the people were warm and friendly, and we had a marvelous time entertaining



DR. AND MRS. LEONARD B. WARRES on the Great Wall of China, with Mongolia at their backs.

(All pictures courtesy of Dr. and Mrs. Warrens.)

SOME SCENES FROM CHINESE MEDICINE: (Top) Patients in a commune clinic outside Canton. (Second down from top) Two patients in one bed. (Third down from top) Patients sleeping head-to-head. (Bottom) Racked surgical gloves.

adorable children and dedicated teachers by spontaneously playing their piano and accordion and singing to them, reciprocating their New Year greetings sung to us. (In Peking, they even had Christmas Eve parties for the first time for all us visiting Americans, providing Chinese acrobats, singers, dancers and other entertainers.)

Medically, the simple commune clinics reminded us of those remote outposts we once visited in the hinterlands of Afghanistan. Families attended patients, newborn babes were sometimes cramped into what looked like drawers, patients were sometimes two to a bed and beds were placed head-to-head! Acupuncture was used for some deliveries and Caesareans.

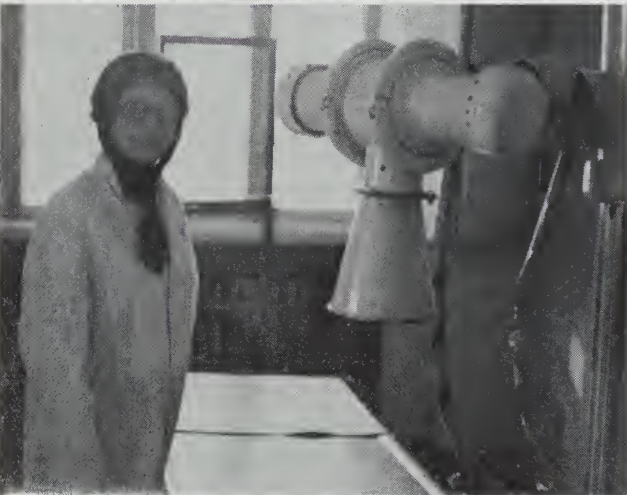
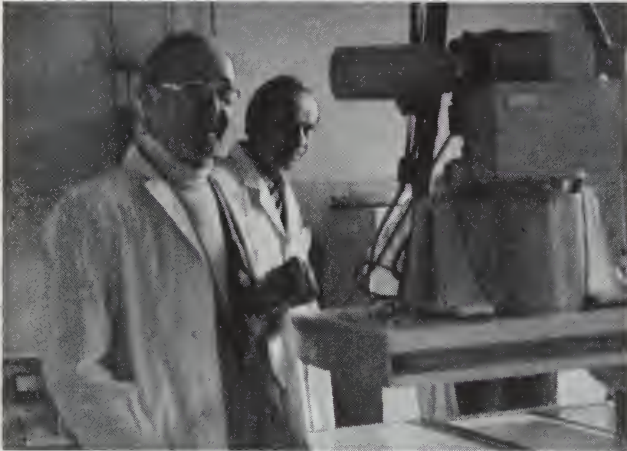
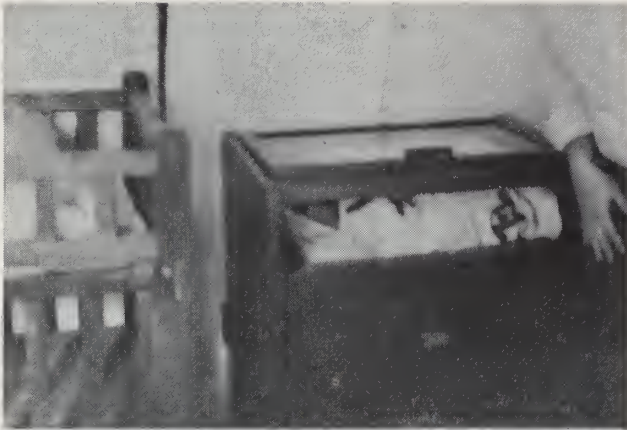
At the Chi Sheui Tan Orthopedic Hospital in Peking, we witnessed the remarkable work and patients of the famous Dr. Cheng who successfully performs anastomoses of severed limbs and digits on accident victims who are brought to him with their parts within 33 hours of injury. A sweet, modest man, he took us on inconceivable rounds to see for ourselves how a toe substituted for a thumb is permitting a worker to regain hand function, how a completely amputated wrist and hand of another patient are growing back together with amazing sensitivity and motion, how a usable amputated foot was switched to the other limb whose foot was destroyed and not usable. (Here the little and big toes were reversed for necessary balance—not beautiful, but certainly functional!) Even outmoded X-ray equipment was well-utilized with good diagnostic results, and the radiologists were impressed with what was being accomplished.

At dinner and during a four-and-a-half hour delay at the Peking Airport (while the runway was being swept clear of snow with a broom—ambulance at the ready!), we utilized the time in memorable discussions with our guides—who were frank to say they would have been arrested for far less two years ago—but now could talk more freely. In their own political group meetings weekly, however, it was obvious that they still remained cautious about expressing differences of opinion and the need for change.

Relationships between young people are more open now, though far more disciplined than in the West. They are coming to resent being overworked and separated from their families and fiancées on distant job assignments dictated solely by the government's pronouncement of "needing them." Even parents are sometimes separated for as long as 10 years—with visitations permitted only twice a year! This our guide acknowledged required remedy—but "steps would take time."

Women do hard labor side-by-side with men—and alone. Many wear masks against the dust of building and road construction. All are garbed in drab Mao pants and jackets, except the children, who are more





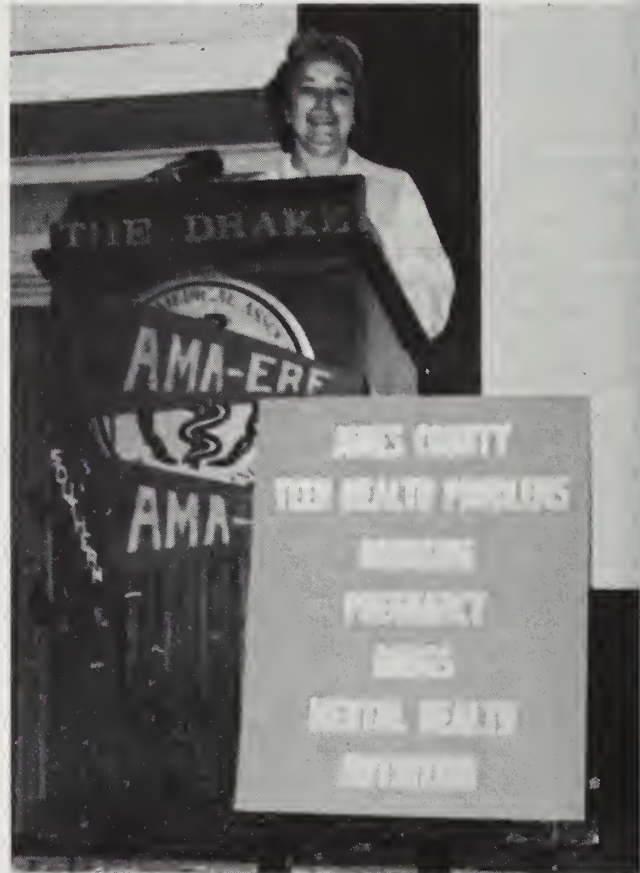
(Top, left) **PEDIATRICS SECTION** in the commune clinic outside Canton. "Yes," says Mrs. Warres, "that's a baby in there!" (Second down from top) **DR. WARRES** (left) with X-ray equipment at the Chi Sheui Tan Orthopedic Hospital in Peking. (Third down from top) **MRS. WARRES** cloaked for hospital rounds. (Bottom) **A VIEW OF THE ANASTOMOSIS OF SEVERED LIMBS** that the author mentions in her story.

colorful. Cotton goods (and meats) are rationed for the Chinese.

Tei chi, slow-motion exercises for physical fitness, are done early each morning outdoors and finished by 7 AM, when everyone disperses for duties. Jogging and badminton are also popular.

There is much "catching up" to be done in China economically—and air pollution is surprisingly a big problem (from their smoky coal and coke-burning vehicles, heaters and factories), but the forces of change have just been unleashed and a new spirit of necessary individual freedoms is abroad in the land—at least among the educated. Where it will lead remains to be seen, but times ahead will surely be exciting and eventful!

(MRS. H. LEONARD) MARGIE B. WARRES



AUXILIARY/MMPAC MEMBER MRS. HELEN BOYER speaking to Auxilians of the 50 states at the 1978 Annual Fall Confluence in Chicago. Mrs. Boyer was National Auxiliary Health Projects Chairman.

(Photo courtesy of the Auxiliary.)

SEMIANNUAL MEETING DATES

Sept. 12-16, 1979—Royal Sonesta Hotel—New Orleans, LA

New Auxiliary President Mrs. Strauss

Mary Maddry Strauss is a native of Richmond, VA, but her accent still places her as being from North Carolina, which she claims is her real home. Following graduation from Durham High School, Mrs. Strauss received her BA degree in English from Duke University. A dean list student, she served as President of the Woman's Student Government Association. Among other campus honoraries, she was listed in **Who's Who Among Students** and, upon graduation, received the Algernon Sydney Sullivan Award.

After teaching Latin and English in Albemarle County, VA, Mrs. Strauss returned to Duke as a member of the Dean's Staff of the Woman's College. In 1963, she married Albert John Strauss, Jr., a senior medical student at the University of Virginia. Following internship at Duke, the couple returned to Charlottesville, where Dr. Strauss completed his residency in pediatrics and Mrs. Strauss continued her teaching and graduate work. She received a Master's Degree from the University of Virginia in 1967.

After a two-year tour of duty with the Air Force at Castle AFB at Merced, CA, Dr. Strauss entered into partnership with Dr. Ronald E. Keyser of Hagerstown; (another pediatrician, Dr. Michael Neimer joined the two in August, 1977.)

Shortly after her arrival in Hagerstown, Mrs. Strauss became active in the Washington County Auxiliary. She served a two-year tenure as Treasurer and two additional years in Vice Presidency positions. (The Auxiliary reached the highest number of members in its history while Mrs. Strauss was Membership Chairman.) She became President in May, 1976.

Upon her installation, Mrs. Strauss wrote to the Medical Society expressing the belief that the Auxiliary could more effectively fulfill its potential if it had representation within the Society itself. It was a unanimous decision; Mrs. Strauss recalls her excitement when she received the gracious letter from Dr. Kit Japzon, Society President, inviting two Auxiliary members to join the Executive Committee in an ex officio capacity. The first representatives from the Auxiliary to the Executive Committee were Mary Strauss and Betty Russell.

During her year in office, Mrs. Strauss assisted in the updating and rewriting of the County Bylaws, making them consistent with the state and national organization. She introduced the Christmas Sharing Card, thereby doubling the county's AMA-ERF contribution over any previous year. The Auxiliary upped its scholarships to three, granting one to a young man for the first time. (In the fall, Washington County hosted the State Board.)

Knowing how Mrs. Strauss enjoys a good laugh, the Doctor's Day Committee of 1978 asked her to write a humorous skit for its March festivities. The result was **Episodes in the Life of Winden D. March, MD**, a three-act playlet starring physicians and Auxiliary members. In covering **Episodes in the Daily Mail**, reporter Libbie

Powell wrote, "This well-written and clever bit of originality on an old theme was the brilliant handiwork of Mary Strauss, who wrote, produced and narrated the work. She was the 'woman of the hour' at its conclusion . . ." (The playwright herself attributes the play's success to the "Phenomenal talent of Washington County.")

In addition to her Auxiliary work, Mrs. Strauss is an active member of Paramount Baptist Church. She was elected the second woman deacon in the church's history and has served in many leadership capacities. Currently, she is completing her fourth year as Sunday School Director. In 1973 she initiated a ministry to the Fairney Keedy Home for the Aged; she continues to direct these monthly programs.

Mrs. Strauss classifies herself as a professional homemaker. She considers mothering three children—Alexandra Elizabeth, 12; Stephanie Lee, 9 and A.J., III, 6—her most important and delightful domestic responsibility. She enjoys cooking and sewing, somewhat wistfully recalling the days when reading, oil painting and knitting occupied more of her leisure time. (Having studied piano for 10 years, she still enjoys playing and is attempting to add some Scott Joplin numbers to her classical repertoire.)

A non-domestic hobby which she enjoys is hunting. Admittedly, she began the sport because of her husband's interest, but now she eagerly anticipates their bi-annual trips to Wyoming where they rough-camp and hunt. She has several buck antelope and one mule deer to her credit.

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family, Mary Strauss is pleased to become the third state president from Washington County. After four years' experience on the State Board, she brings to her new position a deep commitment to the purposes of the Auxiliary and a sincere belief that the organization can and should be a vital, active force which brings recognition not only to itself, but also—and more importantly—to the physicians and Medical Societies which it represents.

Her husband, Dr. Strauss, has been elected President of the Washington County Medical Society and begins his term of office this month, making for two medical Presidents in one family! □

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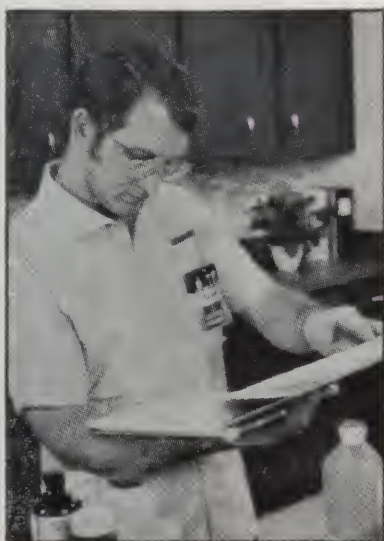
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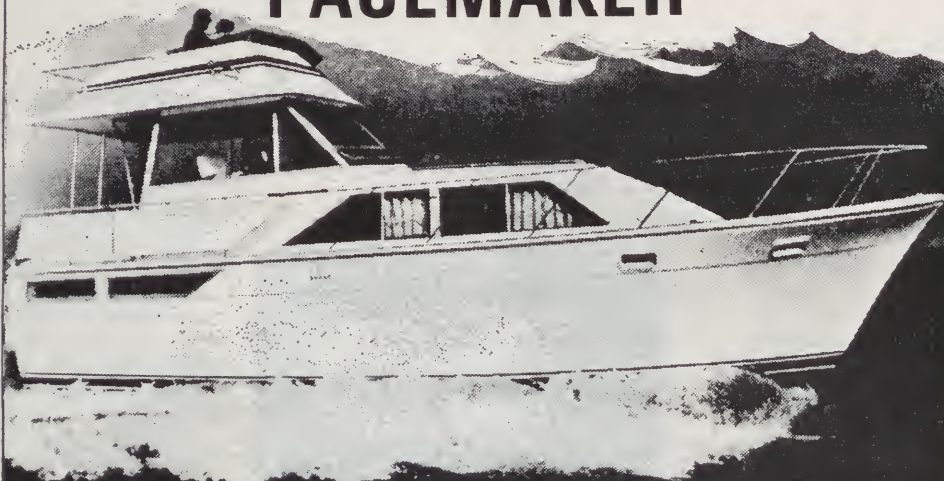
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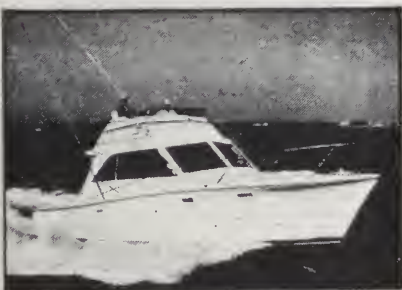
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The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only “expensive” brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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Maryland State Department of Health and Mental Hygiene

CHARLES R. BUCK, JR., ScD, Secretary

Secretary Buck

Governor Harry Hughes nominated Charles R. Buck, Jr., ScD, as Secretary of Health and Mental Hygiene and the appointment was confirmed by the State Senate on Jan. 31, 1979. The new Secretary officially assumed his duties on Feb. 1st, replacing Neil Solomon, MD, PhD, the Department's first and only Secretary since 1969.

Secretary Buck was Director of Planning for the Johns Hopkins Hospital and Assistant Professor of Health Services Administration in the Hopkins School of Hygiene and Public Health. An expert in hospital management, health program planning and reimbursement, he also directed the Municipal Health Services Program of the Robert Wood Johnson Foundation.

His chief responsibilities at Hopkins were to develop long-range goals for programs and facilities for the Hospital and the Hopkins School of Medicine, including expansion of staff, budget and programs for the clinical departments affected by the \$83 million redevelopment program of the Medical Institutions.

Named Director of the Johnson Foundation Municipal Health Services Program in 1978, Dr. Buck administered a national program designed to provide additional health care to underserved, inner-city areas. He

was responsible for administering \$15 million in grants to five major US cities, including Baltimore, to set up medical care programs.

While on the Hopkins staff since 1972, Dr. Buck has been involved in planning for the medical institutions, developing strategies for quality assurance, data processing, cost reimbursement, hospital decentralization, manpower planning and student housing requirements. He had been active in studies on the economic redevelopment of the East Baltimore area as well.

In addition, Dr. Buck had served as a consultant to the Bedford Health Associates, New York State; Bureau of Quality Assurance, Health Services Administration, Department of Health, Education and Welfare; the Robert Wood Johnson Foundation; Analytic Services, Inc. and the Center for Community Health Systems at Columbia University.

A native of Peoria, IL, Dr. Buck obtained a bachelor's degree in industrial engineering from Northwestern University, master's degrees in both industrial engineering and public health from the University of Missouri and a doctor of science from the Hopkins School of Hygiene and Public Health.

He has written numerous papers on health planning and management issues.

Dr. Buck, 37, is married to the former Nancy Shores, and they have two sons, Charles III, 9 and Jonathan, 6.

Dr. Buck's office is located in Room 510 of the Herbert R. O'Connor State Office Building at 201 W. Preston St. in downtown Baltimore. □

Dr. David L. Sorley Named New Chief of the Division of Communicable Diseases

In other news, Dr. David L. Sorley was named Chief of the Division of Communicable Diseases at the Department, according to an announcement by Dr. John L. Pitts, Jr., Director of the DHMH Preventive Medicine Administration.

Dr. Sorley has served as Assistant Chief and Acting Chief of the Division since joining the Department in June, 1977. In this position, he has been responsible for the planning and management of medical programs dealing with the control of all infectious diseases with the exception of tuberculosis.

Dr. Pitts said that Dr. Sorley and his staff will be responsible for providing epidemiological assistance in the investigation of potential or actual disease outbreaks and consultative support to Maryland physicians, local health departments and the general public when needed.

The Division, which is part of the Preventive Medicine Administration, was singled out by the Department of Health, Education and Welfare for managing one of the most effective childhood immunization programs in the nation during 1978.

Dr. Sorley managed rural health care programs in Ambo, Ethiopia for three years prior to acquiring a master's degree in public health from the Hopkins University School of Hygiene and Public Health in 1977.

He is a graduate of the University of Minnesota School of Medicine, and resides with his wife and three children in the metropolitan Baltimore area. □



DR. BUCK

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Radiological

CASE OF THE MONTH

A Service of the Maryland Radiological Society

Co-Editors:

George P. Saba, II, MD

Lee A. Goodman, MD

David McNeely, MD

By JANET F. BROWN, MD; RICHARD CHANG, MD and DARRYL J. GARFINKEL, MD

The authors are in the Dept. of Radiology and Radiological Sciences at the Johns Hopkins Hospital, Balto., MD 21205.

Case History

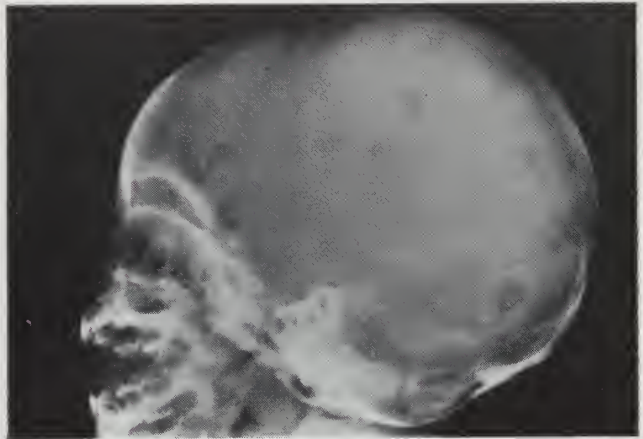
An 11-week-old, white female was admitted for evaluation of anemia and lymphadenopathy. Physical examination at birth was remarkable for a purpuric rash over the trunk, extremities and soles of the feet. These skin lesions faded within several days. TORCH titers and VDRL were normal.

Physical examination at the time of admission revealed moderate hepatosplenomegaly, generalized lymphadenopathy and scattered purpuric lesions. The hematocrit was 18.5%.

The radiographs shown below were taken at the time of admission. (Figures 1A and B, and 2.)

What is your diagnosis?

(Answer on following page.)



FIGURES 1A AND B

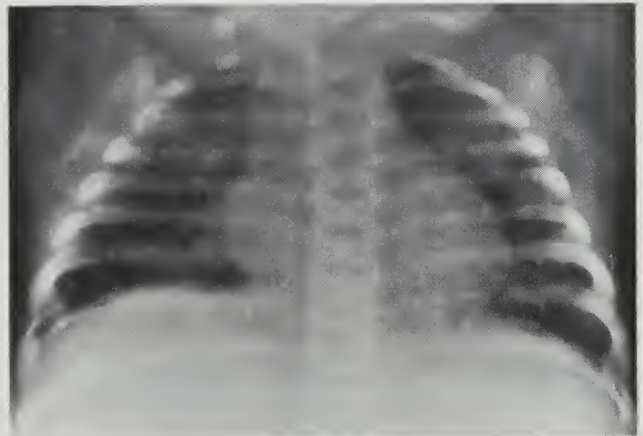


FIGURE 2

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Discussion

Letterer-Siwe disease represents the acute disseminated form of Histiocytosis X. The etiology is unknown. It occurs primarily in children under two years of age; females are more commonly-affected than males. This syndrome is characterized by diffuse multisystem involvement. The classical clinical picture includes a purpuric rash involving the skin and mucus membranes, lymphadenopathy, hepatosplenomegaly, soft tissue masses, anemia, fever and thrombocytopenia. Occasionally, diabetes insipidus and exophthalmus may be present. The course of the illness is usually fatal, but occasionally, complete remission can be obtained.

The roentgen features reflect the generalized systemic picture. Ossous lesions involving the flat bones of the skull, pelvis, scapula, ribs, spine and the major long bones of the extremities are common (Figures 1A and B.) Involvement of the bones of the hands and feet is much rarer. Radiographic enlargement of the liver and spleen parallels the physical examination. Diffuse pulmonary infiltration may also be present (Figure 2.)

The bony lesions appear as lytic, ovoid or rounded defects with well-limited margins, not infrequently-surrounded by slightly-denser, scalloped edges. In the skull, these areas have a serpinginous, map-like appearance, and it is referred to as a "geographic skull." Lesions in the mandible may destroy bone surrounding teeth, which appear to be floating on X-ray exam. Otitis media is often associated with destruction of the mastoid and petrous portion of the temporal bones.


Extensive destruction of a vertebral body with preservation of the adjacent disc space is characteristic. This lesion is probably the most frequent cause of vertebral plana.

The initial roentgen picture of the pulmonary lesion generally is a reticular or fine reticulonodular infiltration, bilateral and usually symmetrical. As the lesions progress, a picture of honey-combing may be apparent. Spontaneous pneumothorax is a frequent complication. There is no hilar adenopathy and usually no pleural involvement.

Treatment of Letterer-Siwe is beyond the scope of this case demonstration. Various modalities including surgery, irradiation and multiple types of chemotherapy are used either alone or in combination.

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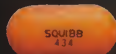
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DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of over-dosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been

reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

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Jesse C. Coggins Memorial Building Dedicated by the Faculty

By BLAINE TAYLOR

(Photography by Joseph E. Jensen, Faculty Librarian).

Contact Mr. Taylor, *Journal* Managing Editor, for reprint and other data c/o the *Journal*, 1211 Cathedral St., Balto., MD 21201.

Dr. Pillsbury Speaks

On Feb. 6, 1979, William A. Pillsbury, MD, then President-Elect of the Medical and Chirurgical Faculty of the State of Maryland (now President) stood before a distinguished group of Free State physicians, Mrs. Jesse C. Coggins (widow of the former Faculty member), Baltimore Mayor William Donald Schaefer and Med-Chi staffers to make the following remarks in memory of the late Dr. Coggins, in whose honor the building at the rear of the present Faculty headquarters at 1211 Cathedral St. in downtown Baltimore was being dedicated:

"It is fitting that the Medical and Chirurgical Faculty dedicate this building to the memory of Dr. Jesse C. Coggins, for Dr. Coggins was not only a builder of a sanitarium—he was also a builder, long before most, of humane treatment of the mentally-ill and the alcoholic.

"Dr. Coggins was a 50-year member of Med-Chi and maintained his interest in medicine until his death in 1963 at the age of 88.

"Dr. Coggins made a generous donation to the Faculty in 1961 in order to establish a lectureship on geriatrics. These lectures have been given every year since 1963 at the Annual Meeting and have been a source of invaluable information to the physicians of Maryland. In his Will, Dr. Coggins made an extremely generous bequest to our building fund, and it is due to this that we are here today.

"We are indeed fortunate and honored to have Dr.

Coggins' widow, Mrs. Helen Alexander Coggins, with us today so she can witness some of the fruits of his and her generosity."

The Mayor's Part

Mayor Schaefer conducted the formal dedication of the building itself, which was formerly part of City Public School No. 49, the renovated gymnasium on Maryland Ave. between Preston and Biddle Sts. The Med-Chi effort represented the commitment of the Faculty to the Midtown-Belvedere renewal area in which Mayor Schaefer has been such a driving force.

The Building

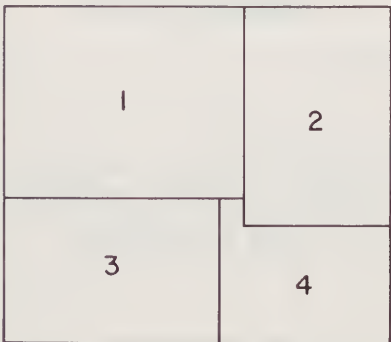
"The two-story building was built around 1900 as a gymnasium for the University School for Boys, a private, non-sectarian, preparatory school owned by William S. Marston. The school was more familiarly-known as the Marston's School for Boys," according to a press release issued by Faculty Communications Director Elza Davis. Further, the release stated, "During the 1940s and '50s, the building was known as School No. 49 or the Robert E. Lee Junior High School. The property includes the main school building facing Cathedral St. immediately adjacent to the present Faculty Building.

"Plans are underway to renovate the main building to serve as expanded headquarters for the medical society. The Coggins Building will house a number of medically-related groups, including the Maryland Psychiatric Society, the Renal Dialysis Network, the Maryland Foundation for Health Care and the Med-Chi Insurance Agency."

A spokesman for the Baltimore City Public School System, William Rock, stated that the City first acquired the entire property in September, 1907, relinquishing it to Med-Chi 70 years later.



DEDICATION SPEAKERS included (left to right) Dr. Russell S. Fisher, the Very Rev. Constantine Monios (both seated), Baltimore Mayor William Donald Schaefer (at podium), Dr. William A. Pillsbury (partially-hidden by podium) and Mrs. Coggins (seated.)



COVER SHOTS: 1) Mayor Schaefer and Mrs. Coggins with plaque honoring the late Dr. Coggins. 2) Building entrance. 3) A larger view of the structure. 4) Dr. Pillsbury speaks; Mayor Schaefer and Dr. Fisher at left.



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Mrs. Coggins

A plaque—to be mounted within the building—honoring her late husband was presented to Mrs. Coggins (who also spoke at the ceremonies) by Mayor Schaefer (see cover photo.)

Other Dedicatory Speakers

Also speaking at the ceremony was the Very Reverend Constantine Monios of the nearby Greek Cathedral of the Annunciation (located at the corner of Maryland Ave. and Preston St.), who gave the invocation, and former Faculty President, twice-Journal interviewee (March, 1977 and April, 1979) and Chief Medical Examiner of the State of Maryland, Dr. Russell S. Fisher, whose topic was **The Medical and Chirurgical Faculty: Its Place in the Neighborhood.**

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Prophylaxis of Thromboembolic Disease

By MATTHEW J. GIBNEY, III, MD

Introduction

The goal of this paper is to help practitioners form a realistic philosophy about prophylaxis of thromboembolic disease. There is increasing evidence that venous thromboembolic phenomena may be a preventable complication in many hospitalized patients. Evidence of previous thromboembolism can be found in more than 60% of routine autopsies.¹ Pulmonary embolism is a frequent postoperative complication in general surgery, orthopedic and gynecology patients. It is the most common cause of death in the elderly injured.² The average general surgeon can expect two deaths every five years from pulmonary embolism. If prophylaxis was 80% effective, 4-8,000 lives could be saved annually in the United States.³ Non-fatal pulmonary embolism is three times as common as fatal pulmonary embolism.

Major surgery causes changes in blood coagulation:⁴

Increased plasma procoagulants

Increased fibrinogen levels

Thrombocytosis (Sharnoff has shown a release of megakaryocyte products from the lung under stress, contributing to hypercoagulability.⁵)

Increased platelet reactivity

Defective fibrinolysis.

These changes in blood coagulation are augmented by:⁶

Venous stasis of recumbency/immobilization

Advanced age

Obesity

Neoplasia

Congestive heart failure

Trauma to the lower extremities

History of previous thromboembolic disease

Oral contraceptives.

Most physicians have patients that fit several of these categories.

•

Over 85% of pulmonary embolism is from the lower extremities. Most of the remaining 15% are from the pelvis and inferior vena cava. Patients with blood group O have been reported to have a lower risk of thromboembolism; 50% of clots at and above the popliteal level can be expected to embolize.⁷

Therapy after pulmonary embolism is often too late. Two-thirds of deaths from major pulmonary embolism occur in the first 30 minutes following the embolization; 50-80% of pulmonary emboli occur without previous signs of peripheral venous thrombosis.⁸ Pulmonary embolism can be misdiagnosed, and resultant full heparinization carries up to a 20% incidence of bleeding complications; therefore, prophylactic measures are necessary in selected patients to prevent

exposure to several unnecessary risks. By ¹²⁵I-labelled fibrinogen scan (a highly reliable non-invasive study⁹ and phlebography, deep vein thrombosis has been diagnosed in:¹⁰

Stroke	60%
Hip fractures	54%
Open prostatectomy	50%
Myocardial infarction	34%
General surgery patients over age 40	28%
Gyn. patients with abdominal procedures.	20%

Two percent of unprotected patients over 40 who have elective hip surgery can expect to die from pulmonary embolism.¹¹

Coagulation

Hemostatic repair starts with local release of ADP from the injured blood vessel wall. Attracted by this, platelets adhere to the exposed collagen and subendothelial structures, releasing more ADP from the platelets. The platelet mass provides a lipid surface (Platelet Factor 3 - PF-3) acting as a catalyst for the coagulation process. Also, thromboplastic substances activate the extrinsic coagulation mechanism, and activate factor XII which initiates the intrinsic mechanism. There is a "cascade" of activation by the two pathways (Figure 1).¹²

Low-dose heparin interrupts the coagulation cascade by inactivating the activated Factor X (X_a) at the common pathway. Thrombin, the subsequent activated form of prothrombin, is the most potent activated factor. It potentiates factors V, VII, VIII and X and enhances platelet aggregation. Full heparinization is required to block the thrombin-to-fibrinogen step of coagulation.

Arterial thrombus (white thrombus) is primarily platelets with relatively little fibrin. Platelets adhere more quickly than fibrin. Venous thrombus (red thrombus) is mainly fibrin from the coagulation cascade.

Anticoagulation

To appreciate prophylaxis of thromboembolism, we must understand anticoagulation. Less is known about anticoagulation than of coagulation.

We are protected from excessive activation of our clotting mechanism by an Alpha-2 globulin known as Antithrombin III (heparin cofactor). This comes from the liver and inhibits several coagulation proteinases of factors VII, IX, X, XI and XII by modifying the serine residue.¹³

During coagulation, factor X operates at the beginning of the final pathway through which essentially all known coagulation activators must pass. This coagula-

tion sequence functions as a biologic amplification system—it takes less energy to stop intravascular coagulation at the factor X_a stage than at the subsequent thrombin stage. Clotting is inhibited without measurable changes of the coagulation profile. Heparin increases the rate at which antithrombin III combines with X_a.³

Birth control pills and estrogens retard the rate of antithrombin III neutralizing X_a, but this is reversed by small amounts of heparin.¹⁴

Coumarin (originally a rat poison) antagonizes the Vitamin K-dependent formation of:

Plasminogen activators are liberated from the endothelium of the microcirculation by vasoactive stimuli, epinephrine, shock, bacterial pyrogens, hypoxia, histamine and tissue damage. It is through this plasminogen activator-antiplasmin balance that the fluid property of the blood is maintained and we are protected from excessive clotting.

Methods of Prophylaxis of Thromboembolism

- Mechanical
 - Elevation
 - Compression
- Medicinal
 - Coumarin
 - Heparin
 - Antiplatelet Drugs
 - Dextran
 - Dipyridamole
 - Aspirin
 - Defibrinogenating Agents.

The end-point of all treatment is early full ambulation. Most deep-vein thrombophlebitis occurs before or during operation (50%),¹⁵ and immediately postoperatively with its hypercoagulability, dependency and sluggish flow. Spinal anesthesia is not recommended with anticoagulation.

Elevation is simple and accomplishes venous drainage, but one cannot always maintain elevation pre-, intra- and postoperatively. It is of modest value.

Elastic Stockings. Ace wraps are imprecise and can tourniquet. Teds-type thigh-high stockings have been shown to significantly increase clearance of contrast material from deep veins intra-op in 18 minutes as opposed to the patient's other leg control of 32 minutes.¹⁶

Leg Exercises are useful and physiologic, but of short duration and cannot be done under anesthesia.

Electrical Stimulation of Calf and Pneumatic Compression are more effective, but cumbersome.

Prophylaxis by medication can maintain a continuous level of anticoagulation.

Coumarin. In several ways, this is superior to low dose heparin. It has even been used successfully to prevent intraoperative implantation of tumor cells.

15 mg PO night before operation

Maintain Pro Time 1½ times normal

No Increased transfusion requirement

Interacts with other drugs

May skip dose on day of operation.

In a study of hip fractures by tagged fibrinogen scan Sevitt showed significant effect of coumarin prophylaxis (Figure 3).¹⁷

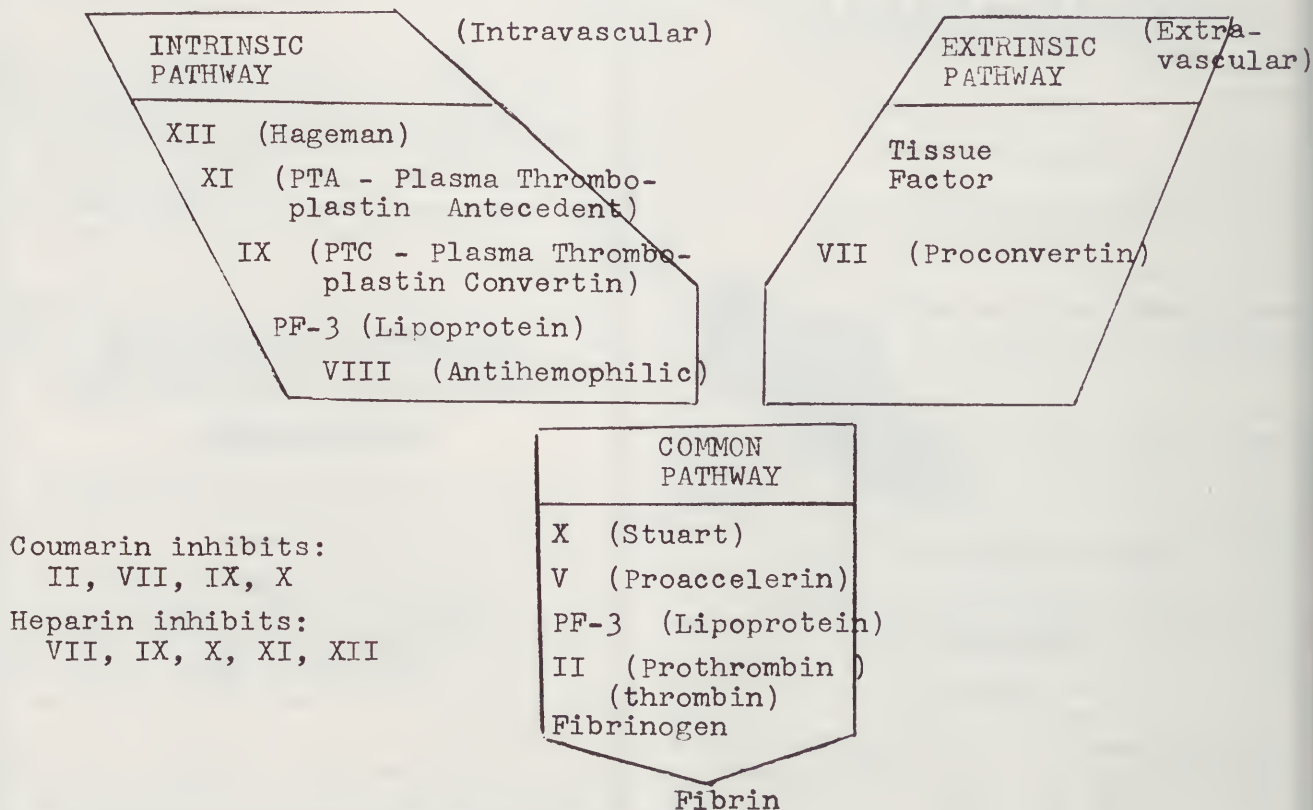


FIGURE 1

Coumarin inhibits:
II, VII, IX, X

Heparin inhibits:
VII, IX, X, XI, XII

Factor	$\frac{1}{2}$ -Life
II	60 hrs.
VII	6 hrs.
IX	20 hrs.
X	40 hrs.

The $\frac{1}{2}$ -life is the reason for the delay in action.

There are coagulation inhibitors (fibrinolysins, plasmins) which digest fibrin and fibrinogen, the thrombolytic system (Fig 2): ¹²

Thrombolytic System

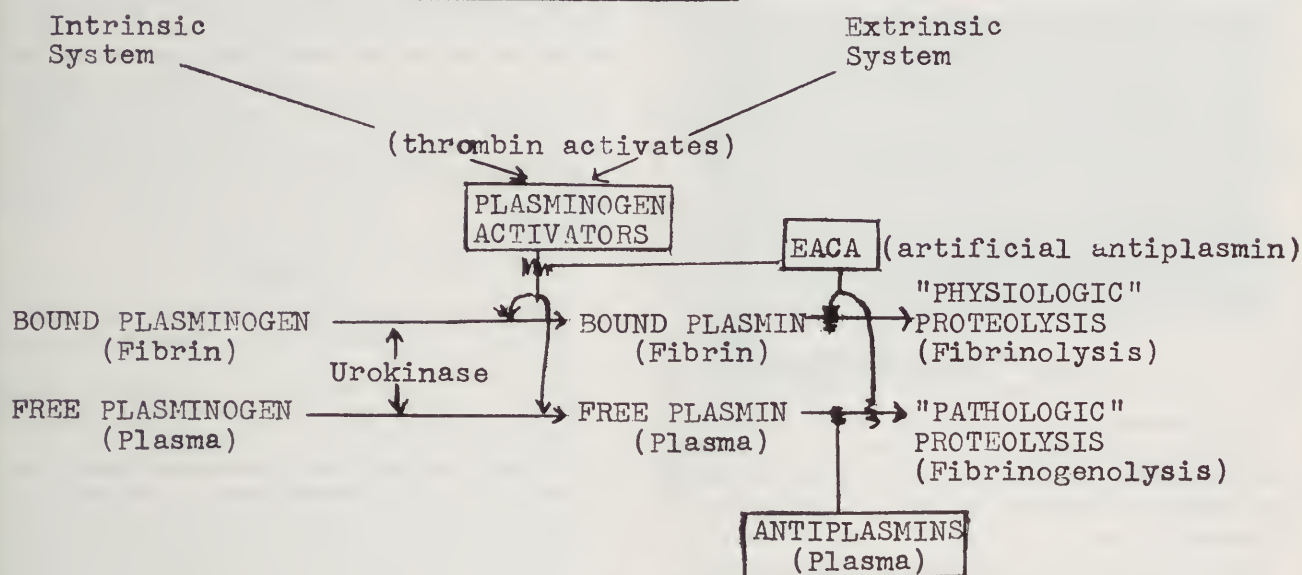


FIGURE 2

Figure 3: Hip Fractures

	Control	Coumarin
Venous Thrombosis	28.7%	2.7%
PE	18%	0
Fatal PE	10%	0

Heparin was discovered by a 2nd-year medical student at Johns Hopkins in 1916. It is made in most cells of man and is not normally detected in plasma. Commercial preparations are made from intestinal mucosa of cattle and hogs, and bovine lung. The $\frac{1}{2}$ -life is $1\frac{1}{2}$ hours, but the disappearance rate decreases with increasing dose. It doesn't cross the placenta as does coumarin.¹⁸

Patients with thrombocytopenia have an increased sensitivity to heparin. Platelets themselves have an anti-heparin activity—"platelet factor 4." One unit of heparin is neutralized by platelet factor from 5×10^5 platelets.¹⁸

Low-dose heparin was first suggested by Bauer in 1954. Sharnoff in 1966 first reported a controlled trial of low-dose subcutaneous heparin.⁵ The current regimen is:

- 5,000 units SQ 2 hrs. pre-op
- 5,000 units SQ q 8-12 hrs. until fully ambulatory
- No coagulation studies are necessary
- Single-dose ampoule is recommended
- Up to a 25% hematoma rate has been reported.

Kakkar reported the most extensive study of low-dose heparin prophylaxis by evaluating 4,121 patients over age 40 undergoing a variety of elective surgical procedures (Figure 4). He reported 16 control pulmonary embolism deaths vs. two pulmonary embolism deaths in the treated group ($p < 0.005$). Although no increased transfusion requirement was reported, heparin was stopped in 3.4%. Wound hematoma rate was significantly elevated ($p < 0.01$).¹⁹

Figure 4: Deep Vein Thrombosis

	Control	Low-dose Heparin
General Surgery ¹⁹	24.6%	7.7%
Elective Surgery ²⁰	16.1%	1.9%
Hip Fracture ²⁰	48.0%	13.0%

How does low-dose heparin therapy compare with coumarin? Ritter at Indiana University compared the two in 300 total hip replacement patients (Figure 5).²¹

Coumarin appears to offer better protection. Average blood replacement, however, is misleading in that hematomas developed more slowly, but in equal number.

Antiplatelet Drugs: Although the bulk of venous thrombus is a red clot with fibrin strands and intermeshed erythrocytes, there is evidence that the initiating event may be a small nidus of platelets that accumulate on an area of endothelial abrasion.

Dextran: either causes a decrease in platelet adhesiveness and/or a defect in the release reaction. Dr. John Bergen of Northwestern University states that dextran antagonizes Factor VIII and markedly increases collateral circulation.²² Low molecular weight dextran is usually used; 20% of the molecules are greater than 50,000 and above the renal threshold. 500 cc. is given during operation and each day for four days, then every three days until fully ambulatory. Bleeding complications are slightly less than those of oral anticoagulants. Studies vary, but dextran is generally less efficacious than low-dose heparin. Pulmonary embolism is decreased, but not deep vein thrombosis.²³⁻²⁴

Dipyridamole: Persantin® has been shown to be ineffective alone in two controlled trials. There is some synergism when combined with aspirin.

Aspirin. A low dose (1 mg./kg.) can prevent release of platelet ADP for up to seven days and prolong the bleeding time. The huge doses of a rheumatoid arthritic (5-16 grams a day for 2-11 days) will prolong the pro time by inhibiting hepatic synthesis of coagulation factors.²⁵ Aspirin suppositories still cause gastric erosion. Aspirin is of proven value in the arterial disorder of amaurosis fugax, but not of the same caliber as coumarin or heparin in venous thrombosis.²⁶ When used, one 325-mg. tablet twice daily is recommended. Antiinflammatory agents are of no value in venous thromboembolism.

Defibrinogenating Agents: A British study using continuous IV infusion of the Malayan pit viper venom Ancrod found a reduced complication of pulmonary embolism, but the same incidence of deep-vein thrombosis, although less extensive in the treated group. There was a reliable decrease toward 100 in the fibrinogen level. There is no proven clinical usefulness yet,²⁷ however.

Cost

Heparin	\$1.32 per 5,000 unit ampoule
Coumarin	\$0.05 each. Pro time \$10.00
Dextran	\$1.48 500-cc. bottle
Aspirin	Negligible.

Conclusion

After reviewing recent literature with all possible permutations of comparisons, it is apparent that prophylaxis is worthwhile to decrease deep-vein thrombosis. We don't see this grossly, but it is readily ap-

parent by phlebography or tagged fibrinogen scan. With prophylaxis, the incidence of documented pulmonary embolism in high-risk patients is reduced from 10-20% to 2-5%. The incidence of wound hematoma is definitely increased, an important consideration. This is certainly unacceptable in intracranial surgery. At times it is necessary to rely on the less efficient mechanical methods of prophylaxis.

In a young man with an uncomplicated inguinal hernia, there is little need for prophylaxis of thromboembolism. In a patient without operation who is at increased risk, you have much to gain by prophylaxis. In the very high-risk patient who may or may not require an operation, you might be out on a legal (not to mention medical) limb if you didn't provide the benefit of prophylaxis of thromboembolism. In these patients, I would recommend prophylaxis with low-dose heparin or coumarin, with dextran or aspirin as second and third-best choices, respectively.

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Figure 5:	P.E.	Phlebitis	Avg. Blood Repl. (500-cc. Units)
Coumarin	0.9%	3.7%	2.5
Low-dose Heparin (2 hrs. preop)	6.5%	9.7%	5.1
Low-dose Heparin (8 hrs. preop)	5.6%	8.9%	3.0
Low-dose Heparin (8 hrs. preop + Hydrocortisone, 100 mg. tid.)	2.2%	10.0%	2.8

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Dyslexia—A Lead Toxicity Symptom?

By BARBARA A. SOLOMON, MD, MA, PA

For reprint and other data, write Dr. Solomon at 8109 Harford Rd., Balto., MD 21234.

Abstract

A pilot study was undertaken with two groups of children compared on the basis of hair lead levels. The higher lead values correlated with dyslexic children. They were treated with ascorbic acid, zinc and other minerals, B complex and placed on a sugar-free diet. Other specific food hypersensitivities were also deleted. The experimental group improved steadily in their scholastic performances, attendance records, lengthened concentration spans and greater emotional stability. Preliminary findings indicate that dyslexia may be a form of chronic low-dose lead poisoning. Cadmium and copper and food hypersensitivities may also be implicated in the dyslexia-hyperactivity syndrome.

Introduction

There is a growing concern among parents and teachers about the problems of dyslexia and hyperactivity among our school children. At the conference of the American Academy of Preventive Medicine in Denver during 1975, Dr. Hitchings reported on the correlation between hyperactivity in children and lead by hair analysis. I felt it would be important and worthwhile to undertake a similar experiment with the patients who come into my office.

Accordingly, I set up two groups of children for studies of hair lead levels. The experimental group consisted of 10 children with reading and disciplinary problems, six of whom had been referred to me by several school authorities. Friends, neighbors and staff members furnished 22 children described as "normal" and well-adjusted for the control group; however, preliminary screening eliminated half that number, six of whom showed evidence of neurological problems.

One I actually transferred to the experimental group. The remainder selected for the control group evidenced no delay in neurological development and no current school problems, and were personally examined by me.

Materials and Methods

Both groups of children were instructed to shampoo their hair seven days prior to a haircut, using no cream rinse or hair spray. Approximately half a cup or two tablespoons of hair was clipped from the nape of the neck of each child and the clippings mailed to Computer Laboratory Services, Inc., PO Box 6293, Dallas, TX 75222. The laboratory's spectrophotometrical analysis tests cross the spectrum for toxic and non-toxic minerals.

I prefer hair analysis because this method is a truer representation of total body lead burden. Blood lead reflects intestinal absorption, which varies from day to day depending upon the amount ingested. In a study of 17 children with lead intoxication, Kopito et al found that tissue "hair" stored lead and recorded the time and duration of exposure and lead accumulation. The hair test results for the experimental and control groups have been tabulated below.²⁻⁴ (Table 1.)

Results

The higher lead values correlated with dyslexic children. The control children showed lead, but a significantly lower amount. The mean lead level of the dyslexic child was 2.44 mg.% as compared to 0.66 mg.% in the control child. The means of the lead levels in the experimental and control groups were compared and the differences of each child from his or her mean was squared. For this small number of samples, the formula for the critical ratio is as follows:

Critical Ratio T test =

$$\frac{\bar{X}_1 - \bar{X}_2}{\sqrt{\frac{S^2}{n_1} + \frac{S^2}{n_2}}}$$

$$S^2 = \frac{\text{Sum } (X_1 - \bar{X}_1)^2 + \text{Sum } (X_2 - \bar{X}_2)^2}{n_1 + n_2 - 2}$$

$$S^2 = 2.468$$

$$\text{Critical Ratio} = 2.5936$$

The probability that the difference between the two groups was due to chance alone was less than 1%.

Treatment

The dyslexic children were treated with ascorbic acid from 1.5-3 gm. per day and zinc 30-60 mg. per day. Dr. Carl Pfeiffer suggests that high level of blood lead may be reduced by zinc and ascorbic acid which acts as a reducing agent and also binds the metal ions that affect the movement across biological membranes.⁵ In addition, the vitamin B complex and other minerals were prescribed as I believe the normal ones such as calcium, magnesium, manganese and chromium have a protective effect against lead poisoning.⁶ Sugar as well as other specific food hypersensitivities were deleted from the diets of the dyslexic children. The loss of urinary calcium due to excess glucose may well predispose the individual to lead toxicity since the freed metal ion site becomes available.⁷

The four experimental children who remained under supervision all seemed to improve steadily in their scholastic performances, attendance records and longer concentration spans. Several were able to drop their special reading classes. They appeared to have greater emotional stability and a higher frustration tolerance. A dramatic improvement followed the removal of specific food allergies, the experi-

mental group averaging from two-five apiece. Most important, there were no apparent side-effects from the ascorbic acid-B complex-minerals-diet therapy as opposed to those occurring in lead toxicity patients treated with EDTA penicillamine.⁸

Case Highlights

JM, a six-year-old boy: Hyperactive, difficulty sleeping, frequent colds. Hard time settling down in school, wiggles. Initial blood serum lead 36 ng./dl.; repeat lead serum level two months later 15 mg. Food allergies: sugar, honey, molasses, gluten. Much less disruptive in my office on second visit, much less hyperactive, fewer colds. Mother reported school said child doing bet-

ter. MB, seven-year-old boy: Failed second grade, couldn't concentrate. Transferred from control group to experimental. Has calmed down, less awkward. Learned to ride a bike.

JG, 10-year-old boy: Learning problems, poor handwriting, poor motor coordination, pains in legs. After six months, teachers reported reading improvement, better concentration, lengthened attention span. When he skipped vitamins, regressed for awhile, but once back on therapy made up for lost time. Last visit reading therapist felt he was now where he belonged, able to compete scholastically with other children.

TM, 11-year-old girl: Mildly-retarded, walked at 13 months, sat up at 6½ months. Subsequently found with abnormal encephalogram for which 100 mg. of dilantin twice a day. High level cadmium only, low level on five normal minerals, high on zinc. Normal serum cadmium 13 months later. Food allergies: sugar, limited tolerance for milk and gluten products. After 15 months' therapy, reading started to improve.

LL, seven-year-old boy: Encephalitis at age four, pneumonia three times, history of allergy, food: sugar, honey, molasses, gluten, wheat germ. Poor motor coordination, difficulty buttoning shirt, speech difficulties, leg pains. After 15 months improved physically, gained eight pounds, jumps and runs faster, less falling down, better coordination. Writing, math improved, better behaved.

JS, 10-year-old boy: Reading problems, short attention span, left strabismus, taking ritalin, poor appetite. After 15 months therapy, able to go off retalin, missed no time from school, report card zoomed from only two Ns to 13-14 Ns. Reading therapist discharged him. Food allergies: sugar, milk products, dates, raisins, figs, wheat, rice and corn.

LW, 14-year-old boy: Fell out of tree house, hit in head with ball, involved in car accident. One reported suicide attempt, diagnosed as schizophrenic at one point. Lead level 7½ times higher than normal, cadmium two times higher and copper four times higher than normal. Food allergies: eggs, milk, beef, poultry, sugar. Improved after two months treatment, then lost to followup.

A repeat hair analysis was performed a year later on two subjects and, to my astonishment, the hair lead level in my star patient had actually risen! I don't know to what to attribute this surprising increase.

Discussion

Niklowitz et al demonstrated that the amount of copper, iron and zinc in the brain tissues decreases as the amount of lead increases.⁹ Lead interference with copper con-

Table 1: Hair Lead Analysis Test Results

Patient	Experimental Group		(X ₁ - X̄ ₁)	
	Lead	Cadmium	diff. from	
	Range in MG% (0.03-0.11)	Range in MG% (.005-0.02)	Mean	(X ₁ - X̄ ₁) ²
1. MB	2.5	0.13	0.06	0.003
2. TC	1.3	0.19	1.14	1.30
3. JG	0.7	1.06	1.74	3.02
4. TH	2.0	0.08	0.44	0.19
5. KH	3.2	0.42	0.76	0.58
6. LL	1.5	0.25	0.94	0.88
7. TM	0.7	0.19	1.74	3.03
8. JM	5.0	0.29	2.56	6.55
9. JS	1.3	0.06	1.14	1.30
10. WS	1.2	0.04	1.24	1.54
11. LW	7.5	0.23	5.06	25.60
	11/26.9	11/2.94	43.99	Total
	2.44*	0.26*		*Mean
Control Group				
1. MD	0.7	0.08	0.04	0.0016
2. ND	0.5	0.11	0.16	0.0256
3. MC	0.6	0.05	0.06	0.0036
4. GR	0.3	0.03	0.36	0.1296
5. JR	0.2	0.04	0.46	0.2116
6. KR	0.6	0.06	0.06	0.0036
7. MR	0.5	0.03	0.16	0.0256
8. BS	2.1	0.11	1.44	2.0736
9. JS	1.0	0.10	0.34	0.1156
10. JP	0.1	0.03	0.56	0.3136
	10/6.6	10/0.64	2.9040	
	0.66*	0.06*		

	Ca	Mg	Na	K	Cu	Zu	Phos	Fe	Mn	Cr	Li
LW 60	4.1	0.1	0.5	12.7	11.0	12	2.2	0.10	0.04	0.01	
GR 40	3.0	3.7	0.4	1.9	1.4	14	7.0	0.01	0.02	0.01	

taining enzymes such as monoamino oxidase and dopamine beta hydroxylase involved in neurotransmitter syntheses or catabolism, can induce neurological disorders recognized as early signs of inorganic and organolead intoxication. Interference with cytochrome oxidase affects metabolic pathways such as respiratory chain and ATP syntheses complex resulting in loss of structural integrity and death of cells and functional disorders.¹⁰⁻¹¹ Niklowitz showed that lead poisoning in humans and animals produced neurofibrillary tangles and vacuolization in the hippocampus and I-II layers of the pyramidal layer of the cerebral cortex.¹²⁻¹⁴

Niklowitz suggests that the displacement of copper, iron and zinc is the doorway by which lead gains ascendancy. The same subjects with high lead also showed high levels of cadmium and copper and low levels of non-toxic minerals. The mean levels of the latter minerals were about the same in both groups except for lower calcium and magnesium in the experimental, but the differences were not significant statistically. There was a considerable range in the individual mineral levels with the highest lead patient and the healthiest control subject displaying the most striking contrast.

Discussion

What is the source of heavy metals in these children? There is atmospheric lead from auto exhaust and industrial pollutants. Besides lead paint, other lead compounds products are pencils, comic strips, pottery and toys. The acidic syrups in softdrink vending machines leach out copper and cadmium during overnight contact.¹⁵ Tapwater is believed a principal culprit for heavy metal poisoning. Copper pipes soldered with tin and lead dissolve into the drinking water if the latter is slightly acid. Afterwards, it occurred to me that these dyslexic children should have been placed on distilled water reconstituted with seawater to obtain the normal minerals.

Conclusion

This pilot study was interesting from several aspects:

- 1) There is an increased amount of repository lead in the hair of dyslexic children as compared to controls. If the dyslexic child has increased brain lead, then dyslexia may be a form of chronic low-dose lead poisoning.
- 2) The difficulties encountered in assembling a lead-free "normal" control group indicates that mild cerebral disorders due to high lead is quite prevalent and pervasive. For the child of extreme sensitivity, even a so-called "safe level" of lead may be toxic.
- 3) Since these children were treated for food hypersensitivities as well as for increased body lead, dyslexia could be a type of "food poisoning" which causes localized or generalized cerebral edema.

Summary

In summary, although I originally started with the simple premise that lead may be related to dyslexia, copper and cadmium may be implicated also. Whether the cadmium-copper toxicities in the same subjects are separate or part of lead intoxication cannot be deduced from these preliminary findings. Whether lead toxicity and food hypersensitivity are cause and effect or parallel phenomena, in common aggravating the clinical syndrome of dyslexia is unknown, but is much food for thought.

The experimental group represents the tip of the iceberg so to speak. Who knows where the bottom is or just what it represents in individual suffering, burdened families, school dropouts and juvenile delinquency? Since dyslexia is becoming more frequent, the aid of other disciplines should be enlisted to solve this human contamination problem. If the sources of lead poisoning are found and corrected, we can prevent dyslexia in children and senile dementia in adults, and spare lead-burdened victims needless pain and suffering.

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Endothelial Stretch Striae in Donor Cornea: Cause, Significance and Prevention

By M.H. ROOZITALAB, MD; J.J. REQUARD, BS; J.A. FOGLE, MD;
W.R. GREEN, MD and C.R. GRAHAM, JR., PhD

This paper is from the Eye Pathology Laboratory of the Wilmer Institute and Department of Pathology of the Johns Hopkins Medical Institutions and the Medical Eye Bank of Maryland. Send reprint requests to W. Richard Green, MD, Eye Pathology Laboratory, John Hopkins Hospital, 601 N. Broadway, Baltimore, MD, 21205.

Introduction

Viable donor corneal tissue is essential for successful penetrating keratoplasty. Recently, we have observed endothelial damage in a number of eyebank donor corneas in the form of parallel and mosaic striae, best seen on retroillumination, and have made histopathologic and ultrastructural correlations of the damaged areas.

We believe that a modification of eyebank technique, along with preoperative inspection of donor corneal buttons for striae, will contribute to the elimination of this as another possible factor for early endothelial failure in grafting.

Case Reports

Case 1: A 27-year-old black male died in an automobile accident. The corneoscleral buttons were obtained by the eyebank technician two hours postmortem and were placed in McCarey-Kaufman (M-K) medium for 12 hours. As the corneas were being prepared for keratoplasty, the eyebank technician (JJR) noted striae on the posterior surface of the cornea. We had the buttons transferred into glutaraldehyde/formalin fixative for further study.

Case 2: A 22-year-old black male died after a stab wound. The corneoscleral buttons were obtained by the eyebank technician two hours postmortem and placed in M-K medium for 11¼ hours. Corneal striae were noted and corneas were transferred into glutaraldehyde/formalin fixative.

Case 3: A 16-year-old black male died of stab wounds. Corneoscleral buttons were obtained by the eyebank technician, who noted striae after removal from the eye. The specimens were prepared for histopathologic examination after having been in M-K medium for 40 hours.

Case 4: A 68-year-old white male died of metastatic carcinoma of the colon. Both corneoscleral buttons were obtained by the eyebank technician five hours postmortem and were found to have posterior striations. The buttons were placed in formalin fixative after removal.

Six corneoscleral buttons (Cases 1, 2 and 3) were fixed in a solution of 4% formaldehyde and 1% glutaraldehyde. Each was bisected, perpendicular to the striae, with one-half button each for light and electron

microscopy. The half for electron microscopy was placed in 2.5% glutaraldehyde for two hours, then post-fixed in 2% osmium tetroxide for two hours, and dehydrated with graded alcohols. These halves were embedded in a mixture of Araldite and Epon epoxy resin (Mollenhauer). Thin sections were obtained and stained with uranyl acetate and lead citrate, and were examined with a JEM 100B electron microscope. Staining for light microscopy included hematoxylin and eosin, Verhoeff-van Gieson and the periodic-acid Schiff reaction.

Regarding the technique of removing corneoscleral buttons, it is generally preferable to obtain corneoscleral buttons from enucleated eyes, because this allows for more precise and careful technique. In medical examiner's cases, however, the corneoscleral buttons are removed from eyes in situ. The accessibility and visualization is less than ideal in these cases. In either instance, a scalpel blade is used to incise the sclera 1 mm. posterior to the limbus at an angle so as to enter the anterior chamber. Curved corneal scissors are used to complete the excision of the corneoscleral button. Care is taken not to allow collapse of the anterior chamber with concave distortion of the cornea. Toothed forceps are then used to grasp the edge of the corneoscleral button and lift it from the remaining portion of the eye.

In most instances, this is accomplished by gentle stripping without any difficulty. On occasion, however, some difficulty is encountered because of residual attachments of the ciliary muscle to the scleral spur. This is presumably due to inadvertent incision behind the scleral spur. In such cases, too strenuous traction on the corneoscleral button leads to distortion of the cornea and tension on the corneal endothelium and Descemet's membrane. This traction is usually the cause of stretch corneal striae. When such attachments are encountered, they should be incised with scissors to prevent damage to the endothelium and Descemet's membrane. The corneoscleral button is then placed in McCarey-Kaufman medium, and stored at 5-10° for several hours.

Results

Light microscopic examination of all these cases disclosed linear areas in which three-to-five endothelial cells were disrupted (Figures 1 and 2). Descemet's membrane and other corneal layers were normal.

Electron microscopic examination revealed endothelial cells and Descemet's membrane to be normal except for the areas corresponding to the stretch striae. There was an abrupt transition from normal endothelium to endothelial cells with ruptured cytoplasmic membranes.

These latter endothelial cells had lost much of their cytoplasm, retaining only nuclei and random organelles (Figure 3).

Associated Descemet's membrane and overlying

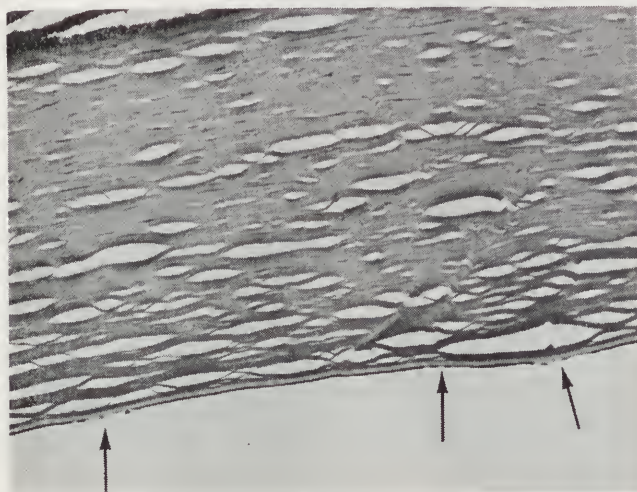


FIGURE 1: Low-power view of cornea showing disruption of endothelium (arrows) by stress-induced striae (Verhoeff-van Gieson, x 185).

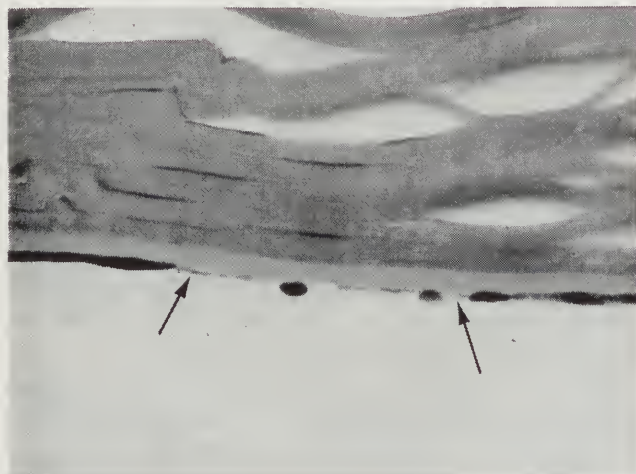


FIGURE 2: Higher power of stretch striae of the cornea (between arrows) showing cellular disruption (Verhoeff-van Gieson, x 700).

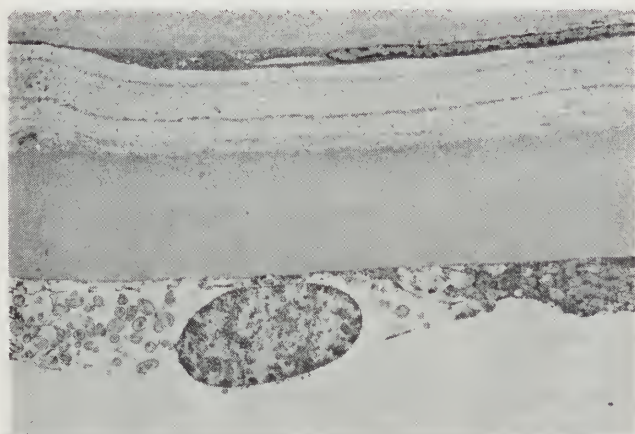


FIGURE 3: Electron microscopic appearance of stretch striae of the cornea showing disruption of endothelial-cell plasma membrane, partial loss of cytoplasmic organelles and relatively normal nucleus. There is an abrupt transition between normal and disrupted endothelium (x 4,400).

stroma were normal in most cases, but in Case #2 vertical cracks in the posterior portion of Descemet's membrane were present in the areas of endothelial disruption (Figure 4).

Discussion

Several factors can be responsible for early graft failure after a technically-successful corneal transplant. An important factor is reduced viability of donor cornea before grafting. There are many points to consider such as age of donor, interval between death and use, preservation technique and systemic and ocular diseases. The biomicroscopic appearance of the donor tissue should be checked in every case. Corneas should not be used for grafting if they show marked foldings, indentations, obvious stromal edema, stromal opacities or, we believe, endothelial striae.

We believe these striae can appear postmortem in an otherwise healthy cornea because of disruption of the endothelial cell membranes by imperfect technique in removing the corneoscleral button from the donor eye. We believe inadvertent incision behind the scleral spur leaves attachments of longitudinal ciliary muscle to the scleral spur and trabecular meshwork. On removing the corneoscleral button without adequate lysis of these attachments, traction on Descemet's membrane and endothelium results in multiple linear areas of stress and endothelial cell disruption. If the force is marked, vertical cracks in the posterior aspect of Descemet's membrane may occur in association with disrupted endothelium. Thus, faulty technique in removal of the corneoscleral button from enucleated eyes, and from eyes in situ, accounts for stretch-induced corneal striae. We have been able to produce such striae experimentally in corneoscleral buttons from eyes with no detectable abnormality on slit-lamp examination before removal.

The focal endothelial disruption can be extensive enough to jeopardize success of a corneal transplant. Although most corneal transplant surgeons can probably cite successful grafts performed using tissue with such gross striae, the effect of endothelial cell-loss is always to be considered. To increase the likelihood of

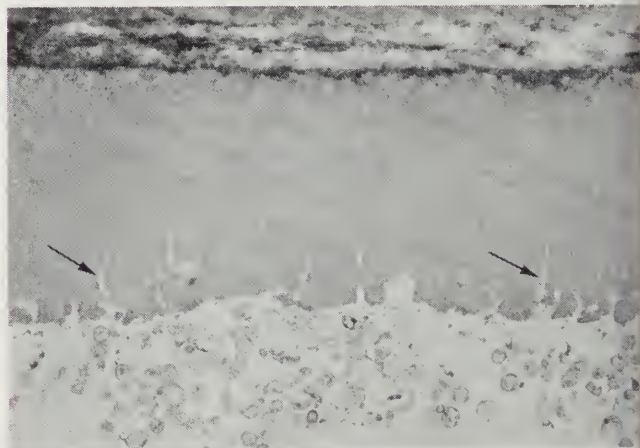


FIGURE 4: Area of stretch striae of cornea showing disruption of endothelium and vertical cracks in the posterior aspect of Descemet's membrane (arrows) (x 5,400).

successful grafting, the surgeon should be aware of the potentially significant cell-loss the striae represent. Careful technique in removal of donor cornea, so as to avoid these striae, is a first step, followed by the surgeon's careful selection of suitable tissue for grafting.

Summary

Light and electron microscopic studies of stretch striae in donor corneas are discussed. The striae occur as lines on the endothelial surface in parallel or mosaic distribution, best seen by retroillumination. Study of these lines by light and electron microscopy showed disruption of endothelial cell membranes, loss of cytoplasm and vertical cracks in Descemet's membrane. We propose that in evaluation of potential viability of donor material, this entity should be borne in mind, as it represents significant physical damage to a tissue largely responsible for graft success. During removal of the corneoscleral button, it is important to avoid applying vigorous force while stripping the corneoscleral buttons from iris and/or ciliary body attachments. The incisions in removing the buttons should be just anterior to the scleral spur, so as to lessen or avoid such adhesions.

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The index is classified according to the Eighth Revision, International Classification of Diseases, US Public Health Service Publication No. 1693. It was prepared by a special hidden medical condition prevalence study committee of the Medic Alert Foundation International Board of Directors.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age. **PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in mid evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

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Aberrant Breast Carcinoma

Case Report and Review of the Literature

By KHEYROLAH ABEDI, MD; LEOPOLDO SALAZAR, MD;
ANTHONY J. RANERI, MD and NEIL NOVIN, MD, FACS

Dr. Abedi was Senior Resident in Surgery at South Baltimore General Hospital, where Dr. Novin is Director of the Department of Surgery, and Assistant Professor of the Department of Surgery at the University of Maryland School of Medicine; Dr. Raneri is Instructor in Surgery at the University of Maryland, and is on the Staff at South Baltimore General Hospital, where Dr. Salazar is on the Senior Attending Staff. Reprint requests should be addressed to Dr. Novin at 3001 South Hanover St., Balto., MD 21230.

Introduction

The occurrence of aberrant breast tissue is not uncommon. Among the Japanese, the incidence is approximately 1.7% among the males and 5.2% among females;^{1, 2} however, carcinoma of aberrant breast tissue is quite rare. There have been less than 80 cases reported in the surgical literature. Our purpose is to report a case and review the literature.

Case Report

T.J., a 71-year-old white female, developed a mass below the right breast which was noted to be approximately two cm. in size in January, 1975. This was excised and found to be duct cell carcinoma in aberrant breast tissue (Figure 1). At that time, no evidence of adenopathy was noted, nor was any evidence of metastatic spread found with extensive workup; therefore, it was decided that no additional therapy would be offered to the patient. She did well until approximately 1½ years later when she noted the onset of a mass superior to the right breast in the midaxillary line, but not in the axilla. This was approximately three cm. in diameter, slightly tender, movable and soft (Figure 2). Again, no axillary adenopathy was noted. Her breasts were found to be clinically unremarkable. Laboratory data, chest X-ray, bone and liver scans were likewise normal. The xeromammogram was reported as showing slightly suspicious calcifications in the subareolar regions bilaterally, and because of the bilaterality and the negative clinical findings, this was not pursued further. The patient underwent an enblock resection of the mass with an axillary lymph node dissection in continuity on June 1, 1976. The pathologic examination of the tissue removed revealed poorly-differentiated duct cell carcinoma with acanthomatous and giant cell features compatible with breast origin (Figure 3). At this point, it was decided that the patient should receive a course of adjuvant chemotherapy along the lines proposed by Bonadonna and others. To date, she is tolerating this well, with no evidence of distant spread or local recurrence having been noted.

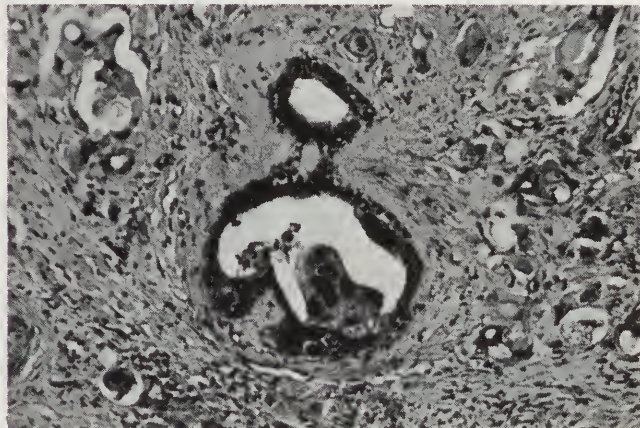


FIGURE 1: Original Biopsy Showing Duct Cell Carcinoma in Aberrant Breast Tissue.

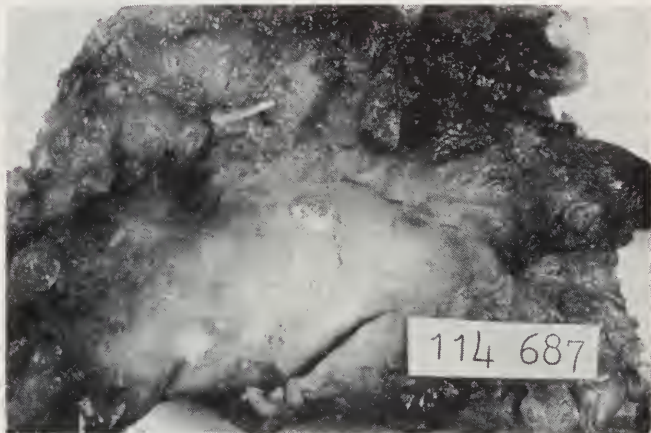


FIGURE 2: Macroscopic Appearance of Recurrent Mid-axillary Line Mass.

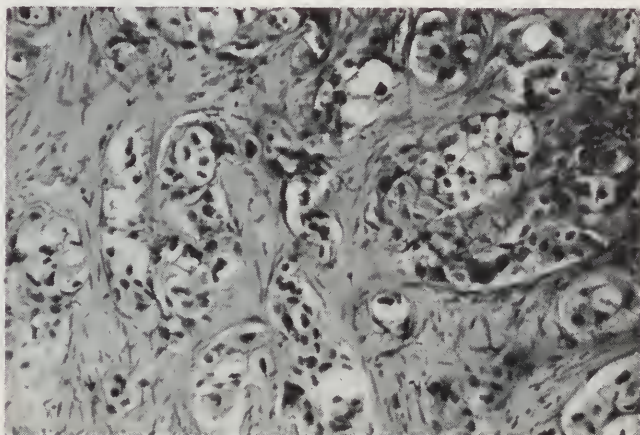


FIGURE 3: Poorly-differentiated Duct Cell Carcinoma with acanthomatous and Giant Cell Features with Breast Origin.

Discussion

Embryologically, two parallel lines of thickened epithelium develop from axilla to groin bilaterally on the ventral surface of the four mm. human embryo. These are referred to as the milk lines. As the embryo develops, there is a conglomeration and localization of this epithelium at the area of the fourth intercostal space where the normal mammary gland usually develops. This accumulation of cells subsequently penetrates the subcutaneous tissue and progressively increases in size.² In the normal individual, the milk lines gradually disappear during embryonal development except for the anlage of the normal breast. When this process is altered for some unknown reason, aberrant formation occurs at other sites along the course of the milk line. Accessory breast tissue, however, may appear at any site along the milk line, but the most common is in the axilla, with the next most frequent site just inferior to the normal breast.²⁻³ When glandular tissue is present in an accessory breast, tumor formation can occur. There is some indication that aberrant breast tissue can be an inherited trait as indicated by Klinkerfuss's report of polymastia in four generations of one family, as well as Peterquin and Iwai's report of inherited polymastia.^{1,4}

Any tumor that may occur in the normal breast can occur in aberrant breast tissue with cancer and fibroadenoma being the most common, and cancer actually occurring more often than fibroadenoma.⁵

In a review of the literature, Story noted that many American and English authors were of the opinion that carcinomatous changes in accessory breast tissue occurred rarely.⁶ A series of patients reported with aberrant breasts with a very negligible or almost nonexistent incidence of carcinoma were on the average in an age group much lower than the age group in which carcinoma usually manifests itself in breast tissue. In Geschickter's series, there were seven instances of carcinoma in aberrant breast tissue, all occurring in the axilla. The ages of the patients varied from 39-69 years.⁶ Chiari, in 1958, found only three cases in a series of 918 patients who were operated on for carcinoma of the breast have included no cases of carcinoma of aberrant breast tissue.⁷ Interestingly enough, there have been eight cases of aberrant breast carcinoma reported involving normally functioning third breast and suggested that the prognosis for aberrant breast tissue may be worse than that of carcinoma of the normal breast.⁸ This may be because of earlier metastases to the lymph nodes or, perhaps, like melanoma of the trunk, the pattern of metastases precludes emblock-type dissections.

Surgical treatment of carcinoma of the aberrant breast will depend on the location along the milk line. Axillary location may well be considered for mastectomy and axillary dissection of both aberrant and the normal breast on that side. Other aberrant locations will determine the type of surgery necessary for adequate excision of the primary lesion.

Geschickter noted only one five-year survival, whereas Smith and Greening in 1972 reported three patients who were treated by local excision of the tumor with addi-

tional axillary lymphadenectomy in two. Postoperatively, each patient received radiotherapy to the axilla and supraclavicular region and, in one instance, 3 years has passed with no tumor recurrence.⁹

Summary and Conclusions

Carcinoma of accessory breast tissue is a rare condition, being most often confused with a subcutaneous lipoma. Cogswell and Dickinson and most other authors believe that excision of the axillary tumor including the axillary lymph nodes and tail of the breast is all that is indicated.^{2, 10-11} However, the mode of treatment at present is obviously undergoing tremendous change with the advent of adjuvant chemotherapy. Groups such as those led by Dr. Fisher in the US and Dr. Bonadonna's group in Italy would seem to indicate that adjuvant chemotherapy has its place in aberrant breast tissue with malignancy where the normal enblock dissection cannot be performed.¹²

It appears to be a logical supplement to the surgical treatment to use chemical adjuvant chemotherapy. It is well-established that the incidence of carcinoma occurring in accessory breast tissue is very low and offers some difficulty of diagnosis. Aberrant breast carcinoma has to be treated by wide local excision, followed by chemotherapy.

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Acknowledgment

We thank Pathologist Dr. Victor Albites for his help in preparing illustrations.

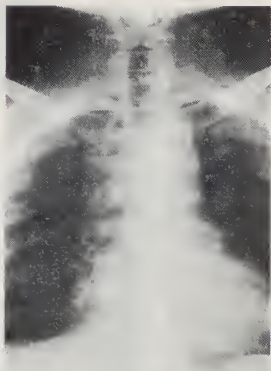
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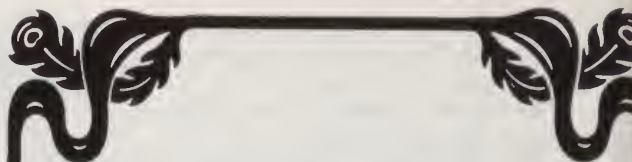
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The Library Page

Questions and Answers

In 1978, the Faculty Library answered 8,870 requests from Faculty members for assistance, a 31% increase over the number of requests answered in 1977. This figure represents the number of MEDLINE searches (1,522), photocopied articles (5,475) and items obtained from other libraries (1,873). While these numbers show the major services offered by the Library to Faculty members, they do not account for all of the Library's activities. In addition, there are telephone reference questions, reference assistance to visitors and circulation of books by mail or interlibrary loan. For now, however, I want to examine the use of the three major services by Faculty members and to use some statistical data to answer questions raised on the Faculty's membership survey discussed last month.

One very common misconception among members who do not use the Library is that only the physicians who live or practice in Baltimore, near the Library, benefit from its services. Many members still believe that they have to come in person to the Library to take advantage of it. On the 1978-79 membership survey, several physicians indicated that the Library's location in Baltimore was too far away for them to make use of it.

Of the 8,870 uses made of the Library's major services (MEDLINE, photocopy and interlibrary loan) by Faculty members in 1978, no more than 1% were in response to physicians who came into the Library. The Faculty Library, unlike most other libraries, functions almost entirely by mail and telephone. In all of 1978, only 808 individuals visited the Faculty Library (less than three a day, on the average), and less than half

of these were physicians. Even those Faculty members in Baltimore who use the Library rely primarily on mail and the telephone. In fact, the Library's records of the individual physicians who used the Faculty Library in 1978 show that the physicians in the county used the Library far more than the physicians in Baltimore City.

Some physicians wrote on the membership survey that they have no need of the Library, since they do not do research or write papers; however, very little of the use made of the Faculty Library is related to research. The majority of the questions that come to the Library are oriented to patient care. Most of the physicians who use the Library are seeking information related to the patients they are currently seeing.

Some physicians indicated that they keep up-to-date with subscriptions to their own specialty journals. It is difficult to define "keeping up-to-date," but a physician would have to be actively reading at least several medical journals in his specialty to keep up with just one-third of the developments in his specialty (assuming he subscribes to the right journals!). He would have to read an additional 35 journals to keep up with the second third of the developments in his specialty. Does any physician find time to read even seven journals regularly?

Some respondents to the survey indicated that they are simply too busy to read and keep up with new developments, but with the prospect that one out of every 10 doctors will face a malpractice claim in the coming year, can any doctor afford not to take the time to keep current?

All this leads up to the ease and convenience of using your Faculty Library privileges. The physicians who do use the Library ask questions about such matters as current therapy for neurogenic pulmonary edema, the effects of vitamin B₆ deficiency in pregnancy or the current status of implantable prostheses for treating urinary incontinence. In response, these physicians receive copies of two or three recent articles, or a list of references from which they can choose items to be sent to them.

Physicians who do use the Library regularly have said that every physician in active practice sees at least one patient a day that raises some kind of question: "What is new in this area? What is the latest treatment? 'Have opinions changed about side-effects or complications?'" Little effort is required to jot a one-line note on your stationery, "Please send me two or three recent articles about" and mail it to the Faculty Library, or, if you choose, you can send requests through any hospital library to which you have access.

As a member of the Faculty, you are entitled to up to 50 pages of photocopy each month at no charge; that amounts to about 10 articles. You will not find a les

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to members of the Faculty during the month of February, 1979:

- | | |
|---|--------------|
| 1. Spontaneous cancer remissions | 39 citations |
| 2. Thorium and Magnesium in relation to pneumoconiosis | 21 citations |
| 3. Ultrasonography in relation to hydrocephalus and neural tube defects | 41 citations |
| 4. Acute intermittent porphyria | 17 citations |
| 5. Literature reviews on infectious arthritis | 21 citations |
| 6. Toxicity of seawasps | 16 citations |
| 7. Nasal sarcoidosis | 10 citations |
| 8. Children's athletic injuries | 81 citations |
| 9. Adrenal cortical adenoma and Cushing's syndrome | 18 citations |
| 10. CAT scanning of the chest | 12 citations |

If you would like a copy of one of these searches or would like to have a search on any biomedical topic, call or write the Library.

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Did you know that, of the 100 hours of Continuing Education Credit you must earn every two years to renew your license, up to 60 hours can be obtained by watching Continuing Medical Education videotapes from the Faculty Library and/or by reading and studying medical journal articles and textbooks? Francis C. Mayle, MD is shown here getting some extra CME credit in the Faculty Library.



Did you know that a computer terminal in the Faculty Library can provide answers to your questions about the latest therapies and procedures for most medical topics? Marco Clayton, MD (left) is shown here taking advantage of this service, but you don't have to come in to the Library. Call Mr. Szczepaniak at (301) 533-0872, or write him in care of the Library, Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, MD 21201. Seen are (left) Dr. Clayton, MD and Reference Librarian Frances Yatserich.



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Book Reviews

SNODERM Ed. by Crawford S. Brown, MD, Publisher Waverly Press, Inc. 1978.

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NAVAL AND MARITIME MEDICINE DURING THE AMERICAN REVOLUTION, by Maurice Bear Gordon, MD, Ventnor, NJ, Ventnor Publishers, 1978.

In January, 1778, a Dr. Cochran and the regimental surgeons and surgeons' mates under him sent a letter to General George Washington resigning from the colonial army. The medical officers were protesting the discrimination against regimental surgeons and surgeons' mates in colonial forces that excluded them from sharing in the spoils of battle. Dr. Cochran and his assistants served under General Smallwood, whose regiment had captured a British brig in the Delaware River near Wilmington.

Gen. Washington wrote to Gen. Smallwood insisting that the "gentlemen in the medical line" were entitled to the same privileges as any officers in the division. This account is related in *Naval and Maritime Medicine During the American Revolution* to indicate the regard of the "Father of Our Country" for the medical profession in general. The book also recounts an occasion when Washington personally interceded on behalf of a British naval surgeon to bring about the return of his medical library, which had been captured by colonial forces.

Dr. Gordon's text is a gold mine of information regarding military medicine at the time of the American Revolution, especially as it applied to the Navy. He has consulted libraries and archives of medical societies, universities, historical societies and museums throughout the Eastern United States and England to compile a valuable reference source. Among his topics are the education of the naval surgeon and the medications and instruments available to naval surgeons during the Revolution. A list of American naval surgeons of the Revolution is included, and there are short biographies of a great number of them; 49 plates illustrate the book. Many of these are portraits of individual physicians and copies of title pages from their writings.

Naval and Maritime Medicine During the American Revolution is a credit to Dr. Gordon's scholarship in identifying and searching out the widely-scattered sources necessary to compile this work. The book will please any general reader interested in the history of military medicine, and is available in the Faculty Library, as are all books reviewed here.

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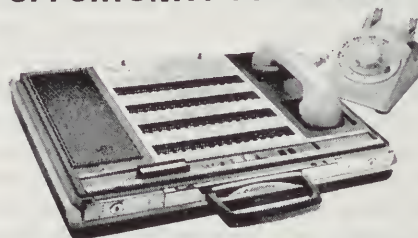
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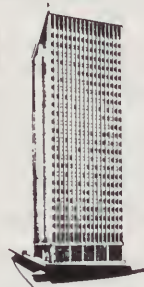
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Doctors in the News



FRANCIS C. MAYLE, JR., MD, right, Faculty President, accepts AMA National Contest for Medical Society Speakers Bureaus awards on behalf of Maryland's two winners, **Raymond J. Donovan, Jr., MD** and **J. Roy Guyther, MD**. The presentation was made by **William Y. Rial, MD**, left, Speaker of the AMA House of Delegates at the 7th Annual AMA Leadership Conference in Chicago recently. Dr. Donovan's First Place award was in the Radio Talk Show category, and Dr. Guyther's award was for Second Place in the Professional Audience category. Prizes of \$1,000 and \$500 respectively were sent to the Faculty for the winning entries.

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Hopkins Cleft Lip Study Still Seeking Mothers

Mothers of children with cleft lip who are planning another pregnancy are urgently needed in a Johns Hopkins research study aimed at finding factors leading to this birth defect. Cleft lip is the second most common birth defect in the US and occurs in approximately one in every thousand births.

"When we initiated our search for women to participate in this study in October, 1978, we got an excellent response from women all over the country. We have found our half of the number of mothers we need to complete the study," according to **Jennifer Niebyl, MD**, Assistant Professor of Gynecology and Obstetrics at Johns Hopkins and Director of the project.

"We are looking for women who either are planning a pregnancy soon, or who are still very early in a current pregnancy," she explains.

Prior research has shown that there is a genetic predisposition to cleft lip, but there may be environmental factors which interact with the genetic factors, according to Dr. Niebyl.

"Cleft lip appears in families, but in such a random way that it is not a predictable genetic problem," Dr. Niebyl points out. "It is possible that there are factors in the mothers' system during pregnancy which may lead to the defect, and we would like to find out what they are."

To volunteer, participants should be:

- a) a mother of a child with cleft lip, with or without cleft palate where neither parent has a cleft lip
- b) less than three months pregnant, or planning to become pregnant soon.

Volunteers are tested by the nurse coordinator, **Laura Rocco, RN**, who takes a routine blood and urine sample. If the volunteer cannot come to Hopkins for the tests, Ms. Rocco may go to the volunteer's home or arrange for blood and urine samples to be sent to the Hospital. Testing is free, and only mothers will be tested.

Women interested in participating in this study should call **Laura Rocco** at Hopkins, at (301) 955-8672. Those outside of Baltimore may call collect.

Dr. Misbah Khan Honored

Med-Chi member Dr. Misbah Khan was recently presented with a Maryland PTA Life Membership. In accepting the honor, Dr. Khan made the following remarks:

"Membership in the Maryland Congress of Parents and Teachers is a rare and singular honor for me. I am proud to be a member of your great organization and to formally join hands with all of you as parents and teachers in a joint commitment to children. You will agree with me when I say that our children teach us more about life's truths than any other single source.

I have learnt that there are no "bad" children—they are whatever we believe them to be. We all know that children who are cherished and cared for, and who know they are, and have been told in so many ways—almost never "go wrong," and live up to all expectations.

I believe that the greatest security for children is first in the adults who surround them, and secondly in all the intangible, immaterial things we as adults provide for them, i.e., acceptance, approval, encouragement, love and giving. The only kind of giving children understand or accept is a giving of self—this means a giving of our time, our presence, our interest and our full attention. If we withhold these, I don't think it matters whatever else we give materially: all the money in the world, all the toys and most expensive gifts fail to register or make up for what is withheld.

I thought a great deal about what I might share with you all today, and I think these are four essential thoughts that I would like to leave with you.

1. First, I believe that we have a grand opportunity today—now—to create a new climate for our children based on our trust of each other. It is the joint and extended thinking of like minds—our minds and ideas—as we share our caring, love and safekeeping of all the children, as our own children. This requires a commitment from all of us to build a trust that is extended from the home, to the school to the neighborhood. It is only our thinking,

caring and support of each other first that will create this new safe climate, this trust in each other, to care for each other's children. It is only a feeling—but it is what makes a community safe.

2. Secondly, let us resolve our adult fears of each other, and our differences. If parents are the primary teachers, then teachers are the secondary parents. Nurturing is a joint adult responsibility, and nurturing does not end with infancy. Husky teenagers need it as much, if not more. Parents and teachers are an indissoluble partnership—their caring, love and trust is like a protective shield for the child at every age. The parent-child relationship, a natural one, is a loving one. The teacher-child relationship is a sacred one—both are like the two sides of a coin.
3. Thirdly, children are really mirror images of the adults who surround them and influence them—all their lives. We are their only role-models—each one of us—they will be no better and no worse than what we are, and what our expectations are of them. Children will live up to the least and the most of our expectations of them. Let us consciously try to have high and great expectations from them of all that is good in them—of all that we believe to be good and true. They cannot do it alone, but I believe they will not fail us. All children of all ages have two basic needs: adult supervision and adult direction.
4. Fourthly, community trust is something we have to build—I believe it is based on our collective caring, and "look-out" for children in the community so that the safeguarding of children is extended from the home and parents to the school and teacher, to the neighborhood and neighbors and friends. How can children remain unsupervised, unsafe, unprotected if we extend this umbrella of caring over their

heads?

It is this feeling that makes for our trust, our dependences on others for caring that which we hold most dear, and most precious."

Agoraphobia Clinic Opened at Sheppard Pratt

Douglas A. Hedlund, MD, Director of the Adult Outpatient Program at the Sheppard and Enoch Pratt Hospital, Towson, MD, has announced the opening of a Group Therapy Clinic for the treatment of Agoraphobia.

In modern terms, Agoraphobia is described as "fear of fear" and its symptoms frequently confine sufferers to their homes or other "places of safety." The new group therapy clinic is designed to help the agoraphobic find new ways of dealing with the anxieties and multiple phobias associated with this condition.

The 90-minute weekly sessions (from 6:30-8 PM) are under the direction of a professional therapist assisted by a co-therapist who is a recovered Agoraphobic with group therapy experience.

Groups are limited to eight, and all persons receive an interview evaluation by Dr. Hedlund prior to group assignment.

For an interview appointment or further information, please call Dr. Hedlund at (301) 823-8200, Ext. 585.

Dr. Van Metre Elected

Thomas E. Van Metre, Jr., MD, of Baltimore, was elected Treasurer of the Joint Council of Allergy and Immunology (JCAI) by its Board of Directors at a recent meeting in New Orleans. The JCAI serves as the socioeconomic arm of the four major national allergy organizations: the American Academy of Allergy, the American College of Allergists, the American Association for Clinical Immunology and Allergy and the American Association of Certified Allergists.

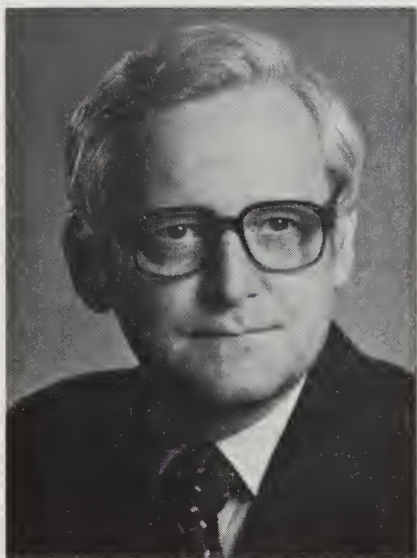
Dr. Van Metre is the President-elect of the American Academy of Allergy. He also is Associate Professor of Medicine and in charge of the allergy clinic at Johns Hopkins Hospital in Baltimore.

Dr. Michels Elected

Dr. Joseph T. Michels was elected President of the Mercy Hospital Medical Staff at its recent annual election meeting. An obstetrician/gynecologist, he previously served two years as Vice President of the Medical Staff.

Other officers elected were: **Dr. Franklin L. Angell**, Chief of Radiology, as Vice President and **Dr. Robert L. Doyle**, Head of the Division of Urology, as Secretary-Treasurer.

Dr. Michels is also President-Elect of the Maryland OB/GYN Society and is a member of the Baltimore City Medical Society, American Medical Association and Med-Chi.



DR. MICHELS

A Fellow in the American College of OB/GYN, Dr. Michels is a graduate of Mount St. Mary's College, Emmitsburg, MD. He received his Medical Degree from the University of Pennsylvania School of Medicine and served his internship and residency at Mercy Hospital.

Dr. Michels has been a member of the Mercy Medical Staff for 20 years and serves on the Medical Affairs Committee of the Board of Trustees. He also has served on other committees of the Medical Staff. He and his family reside in Homeland in Baltimore. □

Coming in the Journal;

Peritoneal Adhesions: Where Do We Stand? by Abdallah Alameddine, MD

Dr. Jerome D. Frank Receives 2nd Annual Blanche Ittleson Award from American Orthopsychiatric Association

Jerome D. Frank, MD, PhD, an eminent clinician and researcher in the behavioral sciences, has received the 2nd Annual Blanche Ittleson Lecture Award by the American Orthopsychiatric Association.

The award, the highest honor the Association can bestow, was presented Apr. 2nd during the AOA's 56th Annual Meeting at the Washington Hilton Hotel in Wash., DC. The title of Dr. Frank's award lecture was **Mental Health in a Fragmented Society—The Shattered Crystal Ball**.

Dr. Frank, Professor Emeritus at Johns Hopkins University, was honored for his lifetime devotion to observing and understanding the function of psychotherapy and developing ways it might serve a greater role in promoting health.

He is a past President of the American Psychopathological Association, and the Society for the Psychological Study of Social Issues and has served on the Board of Directors of the AOA.

Dr. Frank received both his PhD in psychology (1934) and MD (1939) from Harvard University. He received his psychiatric training at the Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital, during 1940-43.

He is the author or co-author of more than 200 scientific articles. His latest books include **Effective Ingredients of Successful Psychotherapy**, New York: Brunner/Mazel, 1978 (with Rudolf Hoehn-Saric, Stanley D. Imber, Bernard L. Liberman, and Anthony Stone) and **Psychotherapy and the Human Predicament: A Psychosocial Approach**: Schocken Books, New York, 1978.

Blanche Ittleson was a New Yorker who spent her lifetime promoting the development of positive mental health programs, particularly on behalf of children. Her efforts played a large role in the development of the World Federation of Mental Health. The first

winner of the Ittleson Award, presented last year, was the late Margaret Mead.

The American Orthopsychiatric Association is a multidisciplinary organization seeking a collaborative approach to the promotion of mental health and the study of human development. □

Dr. Thweatt Named to Editorial Board

Dr. Venita Thweatt, Pediatric Consultant and Director of the Bureau of School Health of the Baltimore City Health Department was recently named to the Editorial Board of the **Journal of School Health**. Published by the American School Health Association, the **Journal** is a monthly magazine for health professionals, principals, teachers, health educators and the medical community.

Dr. Thweatt will review article related to the health of school-aged children being considered for publication in the **Journal**.

Dr. Thweatt received her MD degree from the University of North Carolina and the MPH degree from the Johns Hopkins University. She received specialty pediatric training at the Children's Hospital National Medical Center in Wash., DC. She is a member of the American Public Health Association and the American School Health Association. □

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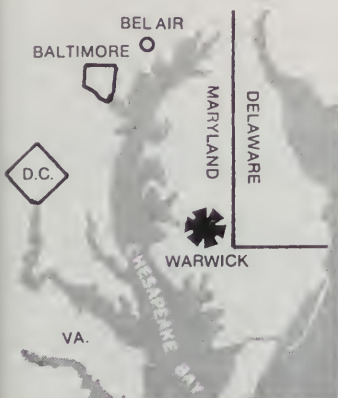
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Doctors Take Note

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Georgetown University Medical School

For details, call Dr. Dean Schuyler, (202) 625-7354. All talks 8-10 PM, Rm. LA-2, Basic Sci. Bldg., GU Med. Campus, 3800 Reservoir Rd., NW, Wash., DC 20007.

May 25, Trtmt.-Resistant Depression, 1-5:15 PM, talk by spkrs. Jan Fawcett, MD and David Kupfer, MD for four hrs. CME cred.

June 6, Transvestism, 8-10 PM, talk by Tom Wise, MD for 10 hrs. CME cred.

George Washington University Dept. of Internal Medicine

All classes, talks, etc. held in Rm. 101, Ross Hall, GWU Sch. of Med. and Health Sci., 2300 I St., NW, Wash., DC. For details, call Dr. Arthur St. Andre at (202) 676-2821. All talks on Weds. evenings, 6:30-8:30.

May 16, Rheumatology II, talk by Robt. Jacobs, MD, 6:30 PM.

May 23, Endocrinology I, talk by Kenneth Becker, MD, 6:30-8:30 PM.

May 30, Endo. II, talk by Dr. Becker, same times as above.

June 6, Renal: Acid-Base, Water Metabolism, talk by Robt. Shalhoub, MD, 6:30 PM, and **Glomerular Diseases (Calculous)** at 7:30 PM.

June 13, Renal: Tubular Dis. incl. Acute Renal Failure, talk by Anne Thompson, MD, at 6:30, followed by **Chronic Renal Failure, Transplantation**, at 7:30 PM.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

June 14-15, Current Drug-Use in Pregnancy.

June 14-15, Occupational Health.

July 11-13, 12th Miles Internatl. Symp., Polypeptide Hormones. Chairman: Roland F. Beers, MD, PhD. For details, write or call Edw. G. Bassett, PhD, Symposium Coordinator, Miles Labs, Inc., PO Box 40, Elkhart, IN 46515; (219) 264-8460.

July 23-27, Educ. Diag. in Pub. Health and Med. Care.

By Appointment, Practical Computer Reporting in Rad.

On-going (Home Study) Postgrad. Course in Intern. Med.

Seven Symposia (Home Study) Highlights of the Topics in Clin. Med.

(Home Study) Echocardiography: Theory and Practice.

On-going Grand Rounds and Clin. Confs.

(Johns Hopkins, Baltimore City and Good Samaritan Hosp.)

Taylor Manor Hospital

For details, contact Frank J. Ayd, Jr., MD, Taylor Manor Hosp., Ellicott City, MD 21043, or call (301) 465-3322.

May 23, Childhood Depression, talk by Leon Cytryn, MD, 3 PM, in Psych. Ctr.

June 20, Psychopharmacotherapy Update, talk by Frank J. Ayd, Jr., MD, Dir. Prof. Educ. and Research, Taylor Manor Hosp. and Clinical Professor, Dept. of Behavioral Med. and Psych., WV Univ. Med. Ctr., Charleston, WV.

University of Maryland

May 11-12, Rehab. of Patients With Stroke or Hip Fracture
For details, call (301) 528-3956.

May 18-19, Problems in Embryonic and Early Fetal Development. For details, call number above.

June 3-9, 5th Anl. Family Med. Review. For details, call above number.

June 15-16, Symposium on Head and Neck Carcinomas. For more data, call above number.

June 21-23, Dermatology Days. Call above number for details.

Other Maryland-Area Meetings

May 9-12, 75th Cong. on Med. Educ.: Med.—A Global Discipline, sponsored by AMA, Wash., DC Hilton Hotel. For details, write Dept. of Mtg. Services, AMA, 535 N. Dearborn St., Chicago, IL 60610.

May 10-12, Decision-Making In Clin. Practice, sponsored by Amer. College of Physicians, in Wash., DC. For details, write Registrar, Postgrad. Courses, ACP, 4200 Pine St., Phila., PA 19104.

June 1, one-day conf. on Anorexia Nervosa, sponsored by the Health and Educ. Council. For details, call the Council at (301) 686-3610.

June 6-8, Purchasing and Managing Med. Instrumentation Internatl. Inn, Wash., DC, sponsored by the Assn. for the Advancement of Med. Instrumentation, 1901 N. Ft. Myer Dr., Suite 602, Arlington, VA 22209 or call (703) 525-4890.

Miscellaneous Meetings

May 12-15, 213th Anl. Mtg. of Med. Soc. of NJ, Convention Hall, Atlantic City, NJ. For details, call Mrs. Marion R. Walton at (609) 896-1766.

May 16-18, Rheumatology, 1979: With Emphasis on New Concepts in Diag. and Management of Regional Rheumatic Disorders, Pittsburgh, PA. For details, write Registrar, ACP Postgrad. Courses, 4200 Pine St., Phila., PA 19104.

May 23-25, Establishing and Accomplishing Organ. Objectives, A Prog. in Management Skills for Health Care Professionals, Natl. Health Care Management Ctr., Wharton Sch. of Med. For details, call Susan Bray, (215) 243-4748.

May 29, Delaware Reg. Mtg., Amer. Coll. of Physicians, Delaware Acad. of Med., Wilmington, DE. For info.: Robt. W. Frelick, FACP, Suite 28, Prof. Bldg. Augustine Cut-Off, Wilmington DE 19803.

May 30-June 1, Sixth Anl. Symp. on Recent Advances and Common Problems in Peds.: A Small Group Approach. Co-sponsored by Children's Hosp., Natl. Med. Ctr., Wash. DC, and the Amer. Acad. of Peds. For further info., contact: Mrs. Susan Weiss, Convention Services/Public Relations, Children's Hosp. Natl. Med. Ctr., 111 Michigan Ave., NW, Wash., DC 20010 (202) 745-3000.

June 4-8, 2nd Annual Diag. Rad. Sem. Fee: \$275 for staff and \$150 for physicians in res. training. Contact: Mrs. Carol Reynolds, Dept. of Rad., Hosp. of the Univ. of PA, 3400 Spruce St. Phila., PA 19104. Cat. I-34 hrs.

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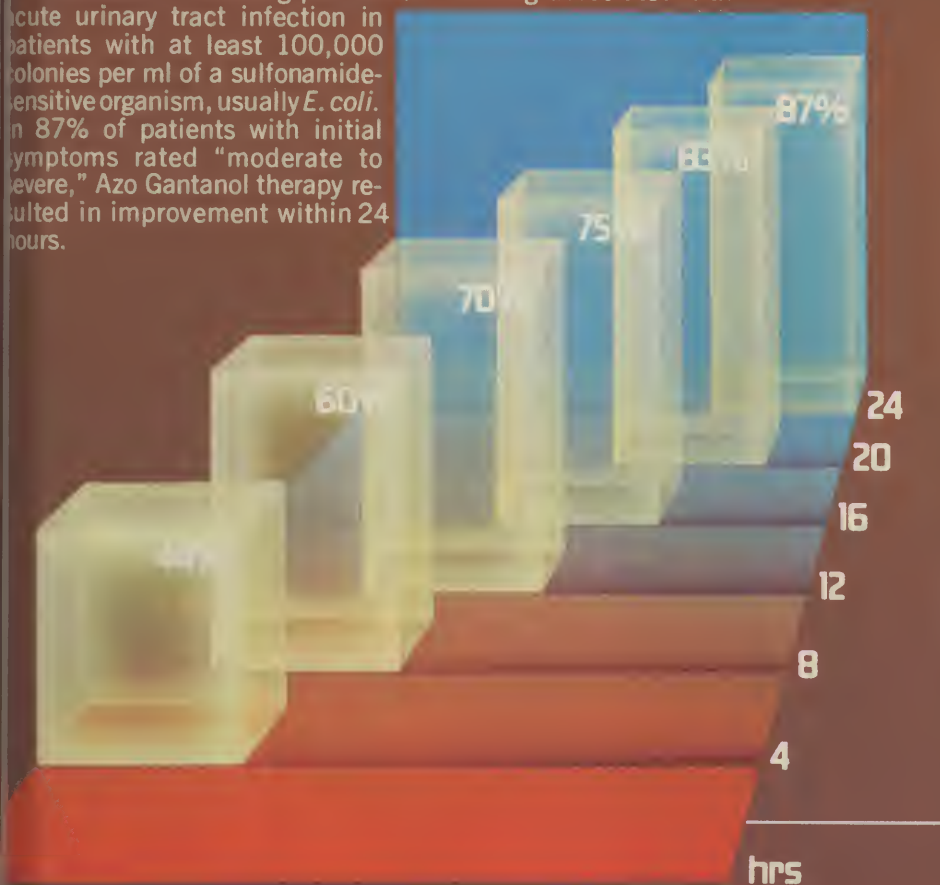
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

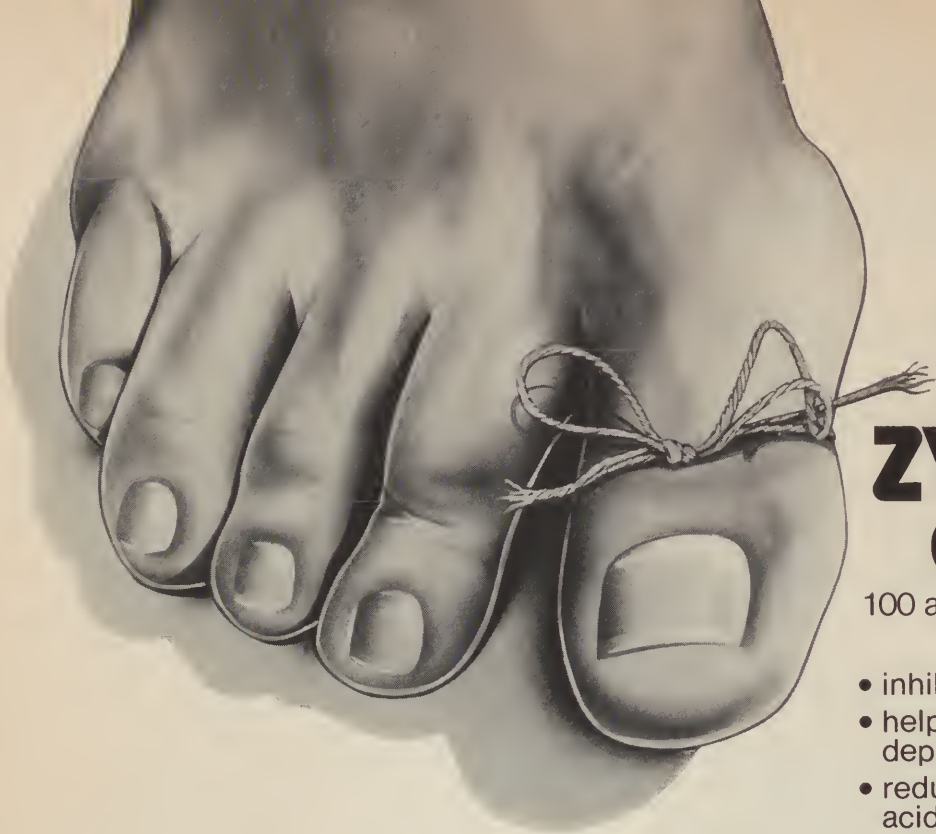
Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
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INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purlinethol[®] (mercaptapurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptapurine or azathioprine. Subsequent adjustment of doses of Purlinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

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COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

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**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl[®]

(dicyclomine hydrochloride USP)

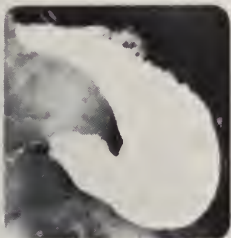
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl® (dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (Syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Medical Miscellany

Vocational Education Program for Adolescents with Epilepsy

Epilepsy is a major developmental disability affecting approximately five of every 1,000 school children. Often it exists with other impairments such as neurological problems, learning and psychological difficulties. Quite often the adolescent with epilepsy is faced with many obstacles to overcome in the adjustment to the disability personally, vocationally and socially. Experience suggests that early intervention is necessary in order to attend to these special needs.

Studies have shown that if a person with epilepsy finishes or drops out of school and is not employed within two years, the probability is that they will never be employed. This teenage period is critical for the acquisition of skills and attitudes and for the establishment of psychological confidence and independence necessary for their development into productive members of the community.

A Supportive Special/Vocational Services Program has been established for students with seizure disorders who are potential vocational education students or those already enrolled in vocational education programs. Its purpose is to improve the opportunities for people with epilepsy and to assist them in preparing for employment.

A coordinated community effort has been undertaken by these agencies: Maryland State Department of Education, Division of Vocational-Technical Education, Division of Vocational Rehabilitation, Region III Baltimore City Educational Unit, Maryland Rehabilitation Center, Baltimore City Public Schools, Division for Exceptional Children, Division of Vocational Education, Johns Hopkins Hospital, John F. Kennedy Institute and Mayor's Office of Manpower Resources.

Membership on the committee providing the general direction of the program is continually expanding to insure efficient use of existing community resources.

The goals of the program are:

To identify students with epilepsy within the schools.

To assess students' needs, aptitudes, interests and goals.

To place students in appropriate job-training programs

To improve medical control of seizures

To increase family involvement and provide family counseling where necessary

To provide individual and group counseling to improve student's attitudes toward themselves and their jobs

To train teachers, nurses, counselors and employers to deal with students who have epilepsy.

To assist students to get and keep appropriate long-term employment.

The major components of the project include:

1. Formal and informal evaluations, including some at the Maryland Rehabilitation Center to determine necessary services

2. Counselors to assist with personal, family, social and vocational adjustment

3. Instruction in job-seeking skills and follow-along assistance on the job

4. An employer committee to create jobs and to formulate new techniques for increasing successful job placement.

5. Assistance toward better seizure control.

For further information, write Nancy Rini, Project Facilitator, Vocational Education Program for Adolescents with Epilepsy, 811 W. Lanvale St., Balto, MD 21217 or call (301) 396-0896.

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The Therapist's Use of Self-Disclosure in Counseling and Psychotherapy: Implications and Considerations For Its Use

By PETER J. POCILUYKO

Mr. Pociluyko is Senior Counselor of the Carroll County Alcoholism Clinic at 540 Washington Rd., PO Box 845, Westminster, MD 21157.

Introduction

The professional distance which sometimes characterizes the physician-patient relationship can be an obstacle in working with the alcoholics. Usually willing to discuss almost anything with his physician except an honest appraisal of his drinking problem, the alcoholic is basically an isolated person walled off by a well-built denial system.

Sometimes self-disclosure by the physician is required before the alcoholic will begin to honestly disclose the role of alcohol in his problem.

The ability and willingness to allow another individual to experience you as you are is perhaps not only a personal choice but also a necessary one. "When a man does not allow or acknowledge to himself who, what and how he is, he is out of touch with reality and himself; consequently, he will sick-en physically, psychologically and/or spiritually. No one can help him without access to the facts and it seems to be another fact that no man can come to know himself except as an outcome of periodically disclosing himself to another person."¹

Upon encountering another individual, we generally begin by seeking knowledge of that person, but we also attempt to allow the other person to know us. This is generally the only way we can co-exist with the inevitable, existential loneliness and separateness that is true of all people. We as people

are all individuals, but it is also our nature to be social; therefore, it is inevitable for all of us to make ourselves known to others, in order to continue to survive and remain healthy.

When we speak of disclosure, we tend to disclose our emotions, opinions, fantasies, dreams and our perceptions, often in explicit, but more often in implicit, ways. "When a man discloses his experience to another, fully, spontaneously and honestly, then the mystery that he was decreases."² Therefore, it seems that to constantly withhold experience or knowledge, can mean that one is maintaining or even complicating the mystery of himself. This is an important point, because we as a culture tend to identify ourselves as a society bent on seeking truth, yet, it is the normality of this culture to hide our feelings, particularly our feelings of anger, because we view these inner experiences as destructive, useless and not socially acceptable. The trap we have fallen into is to view this normal behavior as being healthy, when in fact, it may be pathological (the pathology of normality.³) This constant mystery and denial to one's self and to others, can lead to estrangements from one's true self, often resulting in neurotic or psychotic behavior, depression, suicidal ideations or attempts and in general feeling of meaninglessness in life.

However, this is not a paper looking so much at emotional disturbances due to one's lack of openness and honesty, but rather how those of us who are employed in the helping professions must examine the impact of self-disclosure

in a therapeutic situation. Specifically, I will address self-disclosure, special considerations and implications of its use, and in particular, what the effects of not disclosing ourselves (in a therapeutic situation) may have on our clients.

Let us begin by first examining the given points in all interactional situations. The first point that is not, is that there is no such thing as non-behavior, or put more simply, "One cannot not behave."⁴ If it is also accepted that all behavior in an interactional situation has a message of value, in effect is communication, then it follows that no matter how we try, one cannot not communicate.⁵ Activity, inactivity, words or silence, all have message value; they influence other people and these other individuals, cannot not respond to these communications and are themselves communicating.⁶ Therefore, even if we do not openly verbalize our feelings, thoughts, opinions or values, our behavior nonetheless will communicate these experiences through our non-verbal behavior. This will always hold true, even if we deny the existence of certain inner experiences.

The attempt not to communicate is often the dilemma of schizophrenic individuals, as expressed by their cryptic language, nonsense, silence, withdrawal or any other form of denial.⁷ This behavior is nonetheless communication, leaving these individuals with the impossible task of denying that he is communicating and, at the same time, denying that his denial is a communication.⁸ Communication also implies commitment and thereby defines the sender's view of his rela-

tionship with the receiver; to deny communication is to try to avoid commitment by not communicating.⁹

Let us now move to examining the traditional psychotherapeutic approaches. Upon consulting a professional therapist, the client is usually encouraged to begin by telling all he can about himself, while the therapist listens. This is generally fundamental to all types of psychotherapy, including group or family treatment. It is usually understood by the client that if he reveals himself to the therapist, the therapist will be better able to understand him and to help him change. At this point, a therapist often will sit back, observe and listen. Usually, he will not introject much, if any, of his own thoughts, feelings, conceptions or inner experiences.

In traditional psychoanalytic treatment or psychoanalytically-based psychotherapy, the therapist is allowing a transference to develop, whereby the client projects his distorted conceptions and attitudes of significant others onto the therapist. These conceptions and attitudes may later be analyzed and worked through in long-term treatment, the belief also being that a therapist should not interfere with the developing transference and should not introject his conceptions or experiences into the developing transference (so that the transference is not distorted); yet, we have a paradox in that we cannot not communicate (feelings, values, ideas, thoughts, etc.) and if we deny, refuse to admit or comment on (often by reflective technique) our inner experiences, we are still having a tremendous impact on the client's conception and the developing transference. We often, in fact, (whether we try to or not) are affecting the outcome of the transference; and usually by our subtle cues, (which are sensed by our clients) we are determining the outcome of the transference. In effect, if a therapist expects (consciously or preconsciously) certain types of dreams, conceptions, ideas and feelings, the client will generally begin to have those types of experiences to accommodate the therapist's ex-

pectations. (I would speculate that therapists with low senses of self-esteem or self-concept will generally have more patients reacting in an attempt to please the therapist and make him feel competent; this may be particularly true if psychotherapeutic work is being done with schizophrenic and alcoholic individuals who are extremely adept at seeing our unconscious processes, often better than we are ourselves).

As noted earlier, it has long been believed, in many areas of the helping professions, that a therapist should not interfere with a client's transference or his conceptions projected onto the therapists. In particular, it is felt for a therapist to reveal his personal reactions, feelings, opinions or values, is tantamount to "psychotherapeutic heresy and is interfering with the client's therapy. However, what is not taken into account is that these unexpressed experiences of the therapist (both healthy and pathological) are still being communicated and are being assimilated by the client. Perhaps now, self-disclosure must be looked at as an additional factor, (not exclusive of factors such as empathy, acceptance, insights, interpretation or reframing of behavior) as a useful skill and quality of an effective helping professional in his attempt to assist people to become more independent, stable and healthy.

At times, clients may ask for our reactions which they often have a feeling for long before we give them, by our facial expressions, voice tone and our general overall behavior. What becomes most serious is that if we deny openly to the client (and to ourselves) certain inner experiences, we are "mystifying the experience of the other person."¹⁰ The individual is perceiving one experience through our behavior, is reacting to or commenting on his conception of this experience, but by our denial is implicitly being told that his conceptions are inaccurate. The result may be growing frustration, hostility and confusion, which may sometimes be indicative by sudden relapses and/or a client's premature stopping treatment.

What we are often addressing

here is the therapist's anxiety, not only about self-disclosure, but to "Protect himself from the odious charge of being human—of faltering, in short, of being anything less than God-like."¹¹ There may be the fear that if he reveals his humanness, his technique will be unmasked and that without his technique, he will lack identity. It is a moot point, to note that this anxiety and concern of the therapist will be communicated to the client who, in effect, will also become anxious. Fromm-Reichman¹² has vividly remarked on this when she addresses the importance of the therapist to openly admit mistakes, misunderstandings and potential contrasts in the personalities (of both client and therapist) with any patient; "This can only be accomplished by a psychiatrist or therapist reasonably secure within himself." (This is not a new concept, but was written by a psychoanalytically-trained psychiatrist over 30 years ago; it also shows a rare courage and willingness to look at one's self.)

Too often in their training health professionals—especially mental health professionals—lose their natural and innate qualities for working with people and begin to assume a mask-like quality, because they think this is the professional, expected thing to do.¹³ At these extreme levels, professionals begin to "play act" a role, in effect allowing the role to totally rule their behavior, versus their "assuming" a professional role in that they will allow expression of their human reactions, monitor these reactions and still maintain their therapeutic technique. The paradox is that the therapist's denial and suppression of his human qualities is diametrically opposed to teaching the client how to develop this healthy spontaneity in himself, the absence of which has led to the client's psychological and physical problems.

Jourard,¹⁴ in his clinical work has related how in numerous situations he found that expressing his personal reactions or experience often began leading to breakthroughs in therapy with clients. He found his theory and therapeutic

tic technique still valuable foundations and tools, but he refused to allow his true reactions to always be stifled by "proper technique." He continued to research this phenomena, and found that when an interviewer was willing to reveal information about himself, the interviewees tended to disclose more information about themselves, usually matching the amount of disclosure made by the interviewer. This was in contrast to a totally non-disclosing interviewer who was unable to obtain as much information about an interviewee. Jourard¹⁵ also found that when using a strict reflective technique (the interviewer refusing to disclose himself and always restating questions and statements of the client), the interviewee would strictly maintain themselves to negative self-references. This was in contrast that when an interviewer was more open and self-disclosing, the clients tended to examine both the positive and negative references about self, rather than strictly looking at themselves in a negative manner. (Reflection is still a valuable tool, and is useful in communicating to the client that we heard what he said and allowing the client to hear what he has just told us; however, it should not be our only skill.)



Research by Carknuff and Berenson¹⁶ showed the characteristics of effective helpers consistently included the ability to self-disclose and an ability to use confrontation. Confrontation can be seen as a higher form of self-disclosure—since it involves the therapist investing personal risk. Their research showed that effective therapists willingly went with their empathic conceptions and would challenge a client's distorted perceptions and the clients' incongruencies with regards to his feelings and behavior. It was noted that if a client's distortions and incongruencies were not challenged, it generally meant there was no further growth for the client. This work and that of Jourard leads to my belief that self-disclosure (and confrontation) may have a profound effect on a client's concept of himself, particularly with regard to his/her ability to see both posi-

tive and negative aspects of himself; giving rise to change and growth.

It seems too often therapists place too much emphasis and fascination on understanding psychopathology and do not assist the client in examining or identifying his strengths. This is often manifested if a client is constantly looking for difficulties and problems to be solved rather than looking at the progress and strengths he possesses. (I also suspect many effective therapists can redefine "illogical" disturbed behavior in terms of its logic, and can often relabel that behavior in terms of the individual's attempt to cope in a more healthy way.)

From my overall experience and belief, I have come to view self-disclosure as necessary and useful with regard to individual and family group treatment. Often when working with individual clients, particularly Parole and Probation referrals, various forms of self-disclosure about myself or my background consistently has effected the amount of information I would receive from new clients. It was my experience prior to using self-disclosure on initial interviews that clients would remain resistant and hesitant to disclose any information about themselves. Usually, they would verbally communicate in vague and general terms when specific questions about them or their histories were asked. I have also found this to be especially true when seeing individual adolescents, particularly if they are coming under duress. At times, with "resistant" clients, I have been willing to match any disclosure made on their part with an equal revelation of myself. This has sometimes lead to dramatic movements with regard to the individuals beginning to examine his/her life difficulties and his/her problematic relationship with alcohol.

I have also found that it is sometimes useful to meta-communicate (or meta-disclose), in effect comment on or make a disclosure about a disclosure to a client. There have been situations, where after having expressed annoyance or anger at a particular client, I realized my feelings were somewhat unjustified and defensive, I have found it useful to openly state that my reaction was

in error. I feel that this gives a client a model for which to imitate (in that he can question himself, check his feelings out with himself) and also gives him a sense that the therapist is not an "omnipotent god." In other situations, I will often openly laugh about a particular point a client is making, revealing parts of my humanness. This again tends to set a model for the client to follow, in that the therapist is more willing to show his human side.

In some situations, after treatment has begun and gone on for a period of time, I have found it especially useful to share a past experience which may be similar to the difficulty a particular client is experiencing. I may or may not comment on whether the particular problem was resolved for myself, depending on the situation. In general, if a particular shared concern was resolved for myself, this often may instill a hope of recovery in the client. Even if a particular concern that I disclose has not been resolved, this implicitly communicates to the client that my life is not devastated by not having solved some difficulties, and suggests that the client's life may also not be in jeopardy if his particular situation is not quickly resolved. This may also allow the individual to set priorities about what difficulties he wishes to exert more energy on, versus other problems that may not be able to be resolved or may take more time.

With groups, particularly with groups of adolescents and adult alcoholics, I have found that opening sessions were often easier when I or my co-leader would begin by disclosing our feelings at the beginning of the session. At other times, we have begun sessions by perhaps disclosing something light about our personal life, that was not overwhelming or too deeply personal. We would then ask what other group members felt or were experiencing. It has consistently been my experience, that individuals or groups will not ask for more personal information (as is feared by many therapists if they begin to disclose themselves), but will begin to initiate their own disclosure and

begin working on their difficulties much sooner. At later points during a session, I will often re-disclose my feelings or conceptions, about how the group is working; feelings about how a person's specific behavior is effecting me and that I am curious if it is effecting other group members in the same manner. At other times throughout the session, direct interpretation of group process or behavior may also be used in combination with self-disclosures. It has generally been my experience that individuals or groups will tend to model the role of the therapist, and if he is "tight-lipped," clients will be also.

When using self-disclosure (or confrontation), special considerations should be observed. Self-disclosure involves the therapist being sensitive to his own inner experiences, in conjunction with his willingness to admit these experiences to himself; he need not always disclose these specific experiences to the client. It is only important that he recognize them and not deny them to himself. I note this in particular because many times disclosure is not useful unless properly timed when a client may be most ready to hear it. This, for me, has generally only been learned through experience, the development and sensitivity to individual people and group process (also having good consultation.)

As a model for using self-disclosure, these rules may prove helpful. It is useful to identify; and comment on how such behavior leaves you feeling and your feelings about specific behavior when using self-disclosure. This will generally tend to minimize the possibility of "dumping on" or attacking another individual, in contrast to challenging a specific unhealthy behavior, which is somewhat separate from their essence as people. It may also be useful at times to ask a client if he is interested in our reactions or our conceptions about him/her, as a way to "open the door" of self-disclosure. An additional important point is that when using disclosure there is a point at which an effective therapist can "reach down inside himself" and determine whether this feels to be

an appropriate move on his part. This is noted because disclosure is given for the benefit of the client (though it may also benefit the therapist), and it is not simply for the therapist to ventilate his opinions or feelings. An additional side-light may be that disclosure need not always be limited to personal information, but may also involve a therapist being clear about his agency's specific policies. For example, when referrals are received from the Department of Parole and Probation, often clients wish to know exactly what information will be shared with the courts; and here it is wise for an agency to have, in very explicit terms, what information is valuable for treatment, what is not and what specific information the courts need. Often until clients know these things, they will generally resist talking about themselves and, unfortunately (due to unclear policy about information released in some agencies), are many times referred back to Parole and Probation as being "resistant and hostile" towards treatment.

When using self-disclosure or confrontation, there are additional considerations that must be examined. It must be remembered that transference and parataxic distortions do exist in interactional situations. Many individuals or members of groups may have an initial need to see a therapist as the "all together type of individual," who doesn't possess any problems or may need to see the therapist in another specific way. In opening sessions, it may be wise with some individuals to limit disclosure and respond with social graces. An additional fallacy is that one needs to be completely and openly disclosing at all times. This is generally harmful to the client. I feel that unlimited self-disclosure can be equally as destructive and purposelessness as the attempt not to reveal or disclose any part of ourselves. Any mandate which limits the therapist's flexibility renders him less effective. I have seen some therapists hobbled by a conviction that they must, at all times, be totally honest and transparent and others by the dictum that they must only make

pretations or, even worse, make only mass group transference interpretations.¹⁷ There appears to be some definite need for balance between the use of transference, analysis of that transference and distortion and the use of personal disclosure by the therapist.

Self-disclosure perhaps also needs to be examined in other settings. Kubler-Ross¹⁸ has addressed the problem of dying patients in hospital settings. More often than not, she has found that staff will begin to avoid patients or will put on an air of being happy, trying to avoid any discussion of death or terminal illness. Unfortunately, the patient is the first to notice this change of behavior, realizes that something is wrong and is not being stated, and becomes increasingly anxious waiting for someone to be "upfront." At other times, the patients may not be told what the status of their case is, but their family has been. This also may lead to an uneasy facade which is demonstrated before them, increasing their anger, guilt and anxiety. Kubler-Ross has found that these feelings will quickly subside when staff or family begin to openly acknowledge to each other and to the patient what the status of that person's well-being is.

Jourard¹⁹ has also commented on the role of doctors and nurses who, in their training, are taught to put on a professional mask. The purpose of this mask is to avoid admitting feelings of anger, shame or disgust in front of patients. It also serves to avoid any emotional involvement in the patient's life, the result being that the patient suffers. The style of patient treatment is usually not something which is explicitly taught student doctors and nurses, but is something implicitly learned from their supervisors. Unfortunately, Jourard feels that unspoken experiences that staff have often are expressed to the patient by the staff's abruptness, sharpness and emotional detachment. He feels this may sometimes result in what he calls "The loss of inspiration to becoming well,"²⁰ in essence the individual fails or is slow in recovering from his physical illness because he is beginning to feel

he is being treated like an object.

In psychiatric settings, Stanton and Schwartz,²¹ Kilgalen and Schulz²² and Fry,²³ have all discussed what happens when staff are strongly disagreeing on any level, about any issue, but fail to openly acknowledge their disagreement or feelings of disagreement. More often than not staff may be covertly disagreeing about patient treatment or responsibilities a patient should have. Staff may instead pretend to be friendly, inviting each other to lunch or discussing various other activities.²⁴ When this covert disagreement is going on, the patient the disagreement relates to will suddenly develop symptoms, by becoming assaultive, destroying property, developing extreme anxiety or becoming paranoid. These symptoms are often reflective of these covert staff disagreements.²⁵ It is felt that the open disagreement and anger between staff does not frighten or scare psychiatric patients, but that the denial and refusal to acknowledge these feelings between staff eventually lead to these exaggerated symptoms.²⁶

The authors consequently found that when disagreements were brought out into the open, the symptoms would quickly disappear. They also found that the mere scheduling of a conference of a particular patient who was creating considerable difficulty, usually lead to a decrease in the symptom long before the actual conference took place.²⁷ The conference could be seen as an admission by the staff that a problem is apparent between them and needs to be resolved.

Rubin²⁸ has discussed the importance of revealing anger to patients, in particular psychiatric patients who will not trust a therapist who is not "upfront" and genuine with his feelings. Rubin noted in particular an instance where a patient spat in his face. He angrily told the patient his feelings about the situation and that he would not tolerate this type of behavior from this person. If we examine this closely, we discover that Rubin is communicating several things implicitly. He is placing the responsibility of the behavior on the patient. He is also communicating that

this patient can control his behavior in more appropriate ways, and is assuring the patient that strong, aggressive feelings will not destroy him or the patient (which is a fear many disturbed individuals have about the tremendous amounts of aggressive feelings they possess), that he cares enough to get angry with the patient and has respect for his own self and well-being by openly confronting the patient. It is also noted that Rubin is giving a model for expression of anger, and is giving permission to the patient to express his feelings, since the helper has set the stage by doing so himself.

The speculations of Kilgalen and Schulz, Stanton and Schwartz, Fry and Rubin all seem to coincide with the theories set forth by Laing²⁹ and Batson, et al³⁰ in their belief that many psychiatric disturbances may be the result of the individual growing up in a family system where there was major incongruencies between the expressed feelings and the behavior of family members, often placing the patient in a double binding "Damned if he did, damned if he doesn't" situation. It is important to note that these types of individuals are extremely susceptible to any kind of mystification with regard to how significant people (significant to the patient) are behaving in contrast to their inner experience; in essence, patients will act out if significant people are not being genuine.

Summary

In summary, there has generally been limited research material that is available on the effects of the therapist's self-disclosure in the therapeutic process. Jourard, Carkhuff and Berensen and Yalom have been some of the few authors to openly address this material. Carkhuff and Jourard are the authors who have actually researched this phenomena. Yalom specifically has looked at it from the standpoint of group psychotherapy, and has been one of the few authors who has been able to integrate self-disclosure within its proper place, without allowing it to become the "All or nothing technique." It must also be remembered that self-disclosure

and confrontation in and of themselves cannot be the only tool a therapist has, and are not substitutes for a theoretical foundation for understanding human behavior. It cannot be used in a strict, mechanical sense, but must also be a quality and a function of a therapist's personality and style. If an individual therapist is not comfortable using disclosures as a tool, he should not, but he needs to question himself as to the purpose for withholding all information about himself.

Too often we become only concerned with our efficiency and proficiency for doing therapy, forgetting that we are working with people and not objects. It is also my feeling that additional research has to be developed on the effects of therapists' disclosure and transparency in the therapeutic process, particularly with regard to individual and group treatment.

It also needs to be looked at from a communication theory standpoint with regard to the early years of development and the messages one is receiving from significant others. As also noted, there are many questions in my mind concerning the use of self-disclosure with suicidal clients. If so, under what conditions can it be appropriately used and what, if any, contraindications for its use are there? It may well be a way of communicating hope to a patient who is suicidal, but it may have problems in that it may take away the despair and the frustration that the person may have causing him to feel more misunderstood and hopeless.

In this area, as well as others, further research needs to be developed to examine the impact of self-disclosure on different client populations.

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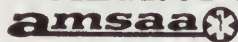
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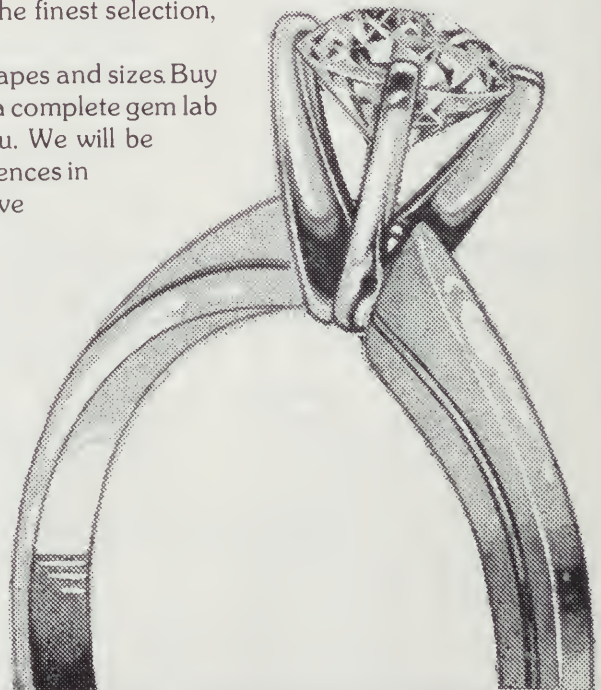
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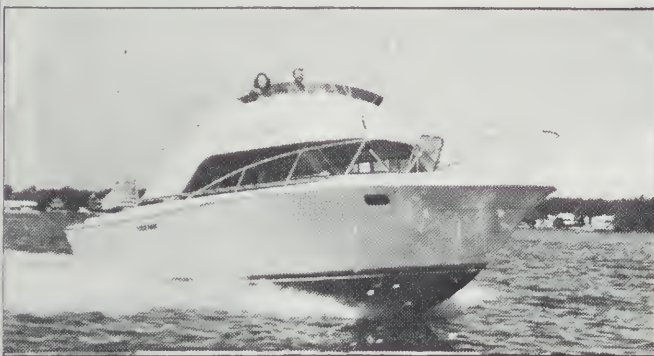
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Officers, Councilors and Delegates Elected

The Annual Meeting of the Baltimore County Medical Association was held recently at the Eagle's Nest in Phoenix, MD. Francis Mayle, MD, President of the Medical and Chirurgical Faculty and Mrs. Mayle were guests at the Luncheon and Meeting. Ferd Kadan, MD was presented his 40-Year Membership Certificate at this meeting.

The following Officers, Councilors and Delegates were elected:

President: Lawrence Misanik, MD

Vice President: Gerald Glowacki, MD

Secretary: John Hebb, MD

Treasurer: Alberto Zapata, MD

Delegates: Lester Kolman, MD; Anthony Stedem, MD; John Krager, MD; William Reichel, MD; J. David Nagel, MD; Elizabeth Sherrill, MD; Herbert Levickas, MD; Adam Szczypinski, MD; Baltasar Velez, MD; Sidney Venable, Jr., MD; Erwin Bacmeister, MD; David Morales, MD; Margaret Sherrard, MD and Ronald Broadwater, MD.

Alternates: John Buckley, MD; Morton Ellin, MD; Richard Lang, MD; Larry Tilley, MD; Robert Barney, MD; William Andersen, MD; Stanley Malinow, MD; Ibrahim Razzak, MD; Ernesto Mendoza, MD; Constantinos Chilimindris, MD; Esther Edery, MD; Stephen Hooper, MD; Jean Posner, MD and Charles Kerr, MD.



FERD KADAN, MD, receives 40-year membership certificate.
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KENNETH B. LEWIS, MD, right, receives Past President's Plaque from **LAWRENCE MISANIK, MD**, the newly-installed BCMA President.



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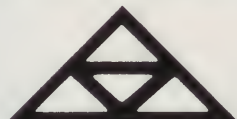
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- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

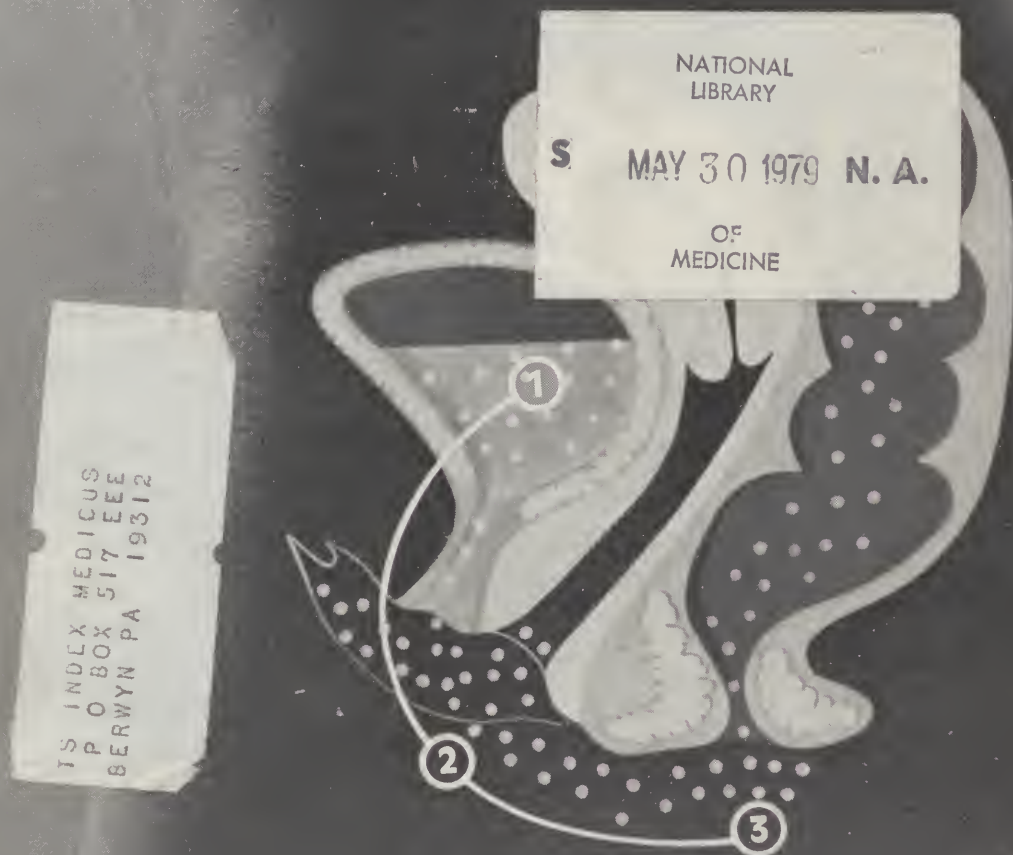
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Please see back cover.

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Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JUNE 1979

MARYLAND STATE MEDICAL



Journal



Ready, Set, Go! Aileen O'Connor Wins the 2nd Annual Lady Equitable Race in Baltimore, March 18, 1979.

(Photos by Joseph E. Jensen.)

Special Section on Running and Jogging:

- * **Run—and Don't Look Over Your Shoulder, Part II** by Philip F. Wagley, MD ... P. 35
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Physicians. Isn't It Time Your Career Had A Check-Up?



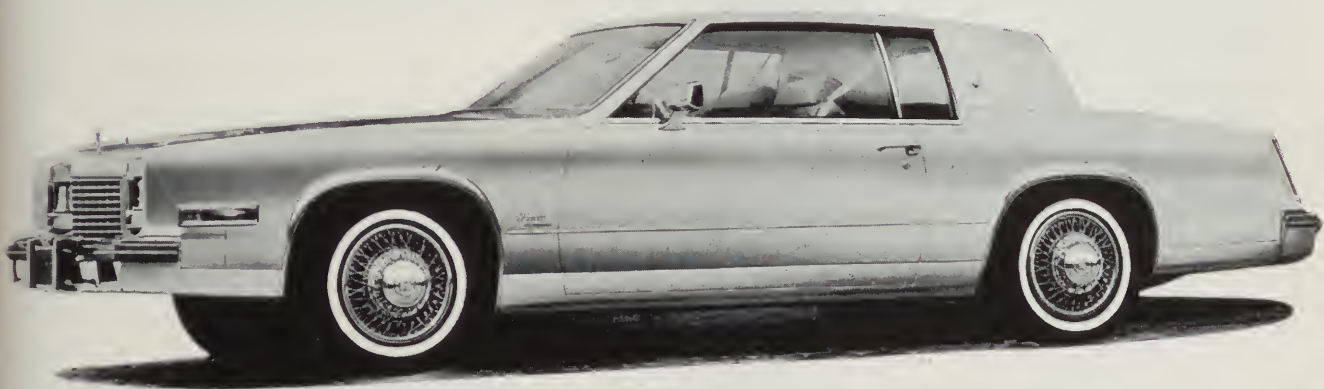
Of course, we don't mean that your career isn't a healthy one. We just want to draw your attention to the career opportunities and benefits the Air Force can offer. You'll discover that the Air Force is a challenging and rewarding way of life. Our hospitals and clinics are outstanding. Plus, we'll pay relocation expenses for your family and household goods when you move. If you're interested in our medical career plan, find out all the facts. Sometimes, even a healthy career could use a check-up.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malforma-

tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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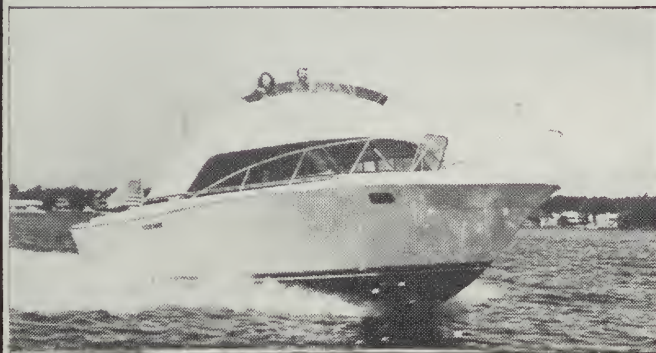


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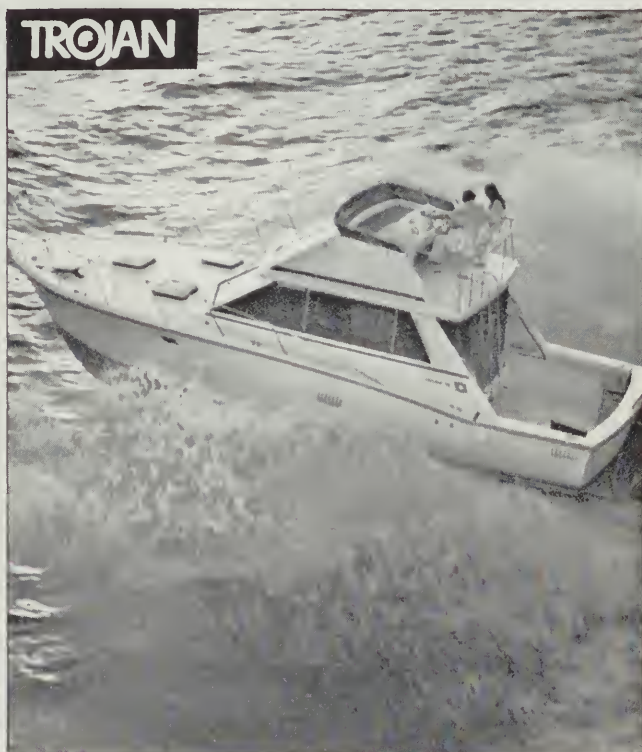
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V-Cillin K^{*}
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

(102175)

***Equivalent to penicillin V.**

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EDITORIAL and BUSINESS OFFICE:
1211 Cathedral St., Baltimore, MD
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Class postage paid at Baltimore, MD.
Accepted at the special rate au-
thorized. Published monthly.
Subscription rates: US, US Pos-
sessions, one year \$8; elsewhere
\$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily
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presents a special section on run-
ning and jogging, beginning on page
35 in this issue.

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

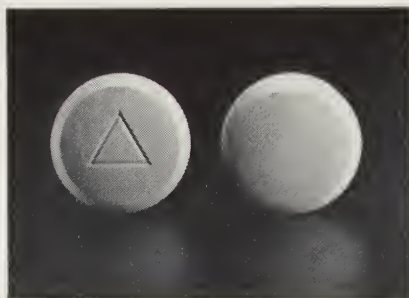
MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

The Open Forum

"Question the Veracity"

To the Editor:

In reference to the recent article (February, 1979—ed. note) on **The Role of Podiatry** by Drs. Harry F. Klinefelter and Neil M. Scheffler, I question the veracity of several of the statements in the article.

Although there is a definite role for podiatry, I found that not all podiatrists have a level of training that are exemplified by Dr. Scheffler and a few of his associates, and question the blanket "carte blanche" professed in this report. Technical skills vary like in other professionals. Specifically, I object to the statement that podiatrists are accepted members of the medical community and have direct patient responsibility and a legal right to make and act upon their own independent medical judgment. This particular statement is a direct quote from the article. Dr. Klinefelter and others certainly realize that although these people have admitting privileges at some hospitals, and have indeed even Residents for their services, they are under the direction of or in another Medical Department for medical expertise and/or control/responsibility. I particularly object to the quotation from Dr. Sherman Coleman, President of the American Orthopedic Association, being used as an insult against orthopedics. The intent in using this is say that orthopedists no longer are qualified for foot surgery and that all foot surgery should be done by a

podiatrist. I certainly do not consider most of the procedures that the podiatrists do at this time as very specialized surgery. Furthermore, many of us in orthopedics have maintained an interest in foot problems.

In conclusion, the most significant information presented in the article is the article's conclusion in which they state that there should be a mutual exchange of ideas and techniques. I have attempted to do this in the past with several members of the podiatry community, but articles like this tend to make me somewhat enflamed and take away from some of the good coordinated activities that have been carried out in the past. This, indeed, is no indictment or any other reflection upon podiatry, except that the article was simply publicity in order to allow the podiatrists to gain a greater position on hospital staffs, but should, I think, be closely monitored by hospital medical staff executive committees in order to ensure quality care in our hospitals.

Thank you for your interest in this matter.

FRANK T. BARRANCO, MD
600 West Northern Parkway
Baltimore, MD 21210

Dr. Scheffler's Reply

To the Editor:

Dr. Frank T. Barranco's comments on our article (**The Role of Podiatry**, February, 1979) are somewhat inaccurate. I do not believe that we suggested that all podiatrists are equally-trained. Variations in residency programs and podiatry school training, of course, do exist. The American Board of Podiatric Surgery and the American College of Foot Surgeons realize these variations and confer membership accordingly, just as corresponding groups in orthopedics do. Incidentally, the skills of orthopedists in Maryland who do not do as much foot surgery as does Dr. Barranco varies quite a bit. This is what Dr. Coleman referred to in his address **Specialty Training**. Podiatrists do just that. We specialize, and I believe that improves the care we give our patients. For the most part, however, the practitioners in Maryland exhibit an extremely high level of competency. As a member of the State Board of Podiatry Examiners, I am in a position to examine and screen applicants for licensure and have been impressed by their knowledge.

The statement regarding "Direct patient responsibility and the legal right to make and act upon their own medical judgment" is correct. In hospital situations, we have independent judgment regarding our areas of practice. The physicians with whom we consult are responsible for the patients' overall medical care—not their foot surgery. All four hospitals at which I work include the Section of Podiatry under the Department of Surgery—a similar status to the Section of Orthopedics.

I am surprised that Dr. Barranco, as a member of the Foot Society of the American Orthopedic Association,

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ation, does not regard foot surgery as "very specialized." I do. How much more specialized can you get than limiting your care to just the foot?

The article was never intended to be an attack upon orthopedics. My personal relations with orthopedists has shown that we can and will continue to work together for the benefit of the patient. Only when some members of the orthopedic community attempt to protect their turf from intrusion by podiatrists who can do similar procedures as well or better than they will there be any air of contention.

NEIL M. SCHEFFLER, DPM, FACFS
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It is with mixed emotions that I accept the position as the 30th President of the Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. At the same time, I feel humility at the confidence placed in me, I also sense great pride at having the opportunity of leading what I consider one of the most vital, most privileged, most influential groups in this or any other state.

Having served as State Membership Chairman for two years, I have been totally indoctrinated with the concepts and techniques of enlistment. With the use of letters, personal notes, workshops, phone calls and on-site visits, I have tried to assist our 13 Component Chairmen in recruiting, retaining and reenlisting members. Out of a possible 5,000 last year, we netted a total of only 893 members. This year, in spite of my best efforts and those of our County Chairmen, we are following a national trend and experiencing a decline. Considering the importance of the Auxiliary, how can this be?

For me, the Auxiliary is not an optional organization. Old-fashioned as it may seem, I still adhere to the concept that when I became married, I made a commitment to my husband—to help him in any way possible—personally and professionally. He is committed to the practice of medicine; I am committed to him; therefore, I am committed to a deep, abiding interest in his profession. The Auxiliary offers me this opportunity as no other organization can. It enables me to extend and enhance my spouse's position in the community. No one can represent him as well as I can, and no organization can represent the physicians of this state as well as the Auxiliary can. If we do not assume the task of providing a unified backing for today's physicians, no other group can or will. Our organization desperately needs the untapped power of individuals if we are to function collectively in an impressive, effective man-

ner. Why, then, are we finding such difficulty in enlisting these potential power cells?

In a recent address, National Auxiliary President Muriel Bergness stated that any organization which is finding it hard to recruit members has simply not kept up with the times. Perhaps before we exert all our energies in enlistment, we need to make an introspective examination of ourselves as Auxilians and determine whether we have indeed kept up with the times.

Could it be possible that we have become so entrenched in a yearly format of "the-way-we've-always-done-it" approach that our potential members are finding more fulfilling opportunities in other organizations? Do we need to enlarge our vision, providing more challenging, long-range projects which call for a sustained involvement? Have we been realistic in accounting for different lifestyles and priorities? The Auxiliary needs unity, not uniformity. There is vitality in diversity of talents, interests and abilities. Have we provided for a diversity of opinions and approaches?

As vital as is enlargement, to expand ourselves collectively without enriching ourselves personally would be an injustice. If we are to communicate intelligently within medical circles, if we are to understand our husbands' concern about HMO, PRSO, HSA, etc., then we must become well-versed in the concepts and the language of medicine today. Only with this kind of awareness can we comprehend the physicians' position; only with knowledge of the truth about the profession can we combat public misconceptions and offer a rebuttle to the deluge of half-truths in articles of the "How-to-Sue-Your Doctor" variety.

One of the greatest benefits of Auxiliary membership is the cultivation of friendships within the professional family. No matter how much we do on behalf of the profession, we should never minimize the blessings of fellowship and friendship within it. There is no substitute for the support and camaraderie offered within the medical family.

This year, I propose that we enlist, enlarge and enrich ourselves within the Auxiliary. How can we possibly accomplish so formiddable a task? It will take much patience and determination but, above all, I believe it will take enthusiasm. Emerson said, "Nothing great was ever achieved without enthusiasm." Perhaps this is the ingredient we need most if we are to achieve the true greatness of which our Auxiliary is so capable.

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Maryland Medical Political Action Committee

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Membership

Unity among physicians remains a top priority item. Some liberal US Senators are trying to push through Congress an all-inclusive National Health Insurance bill. Admittedly, an adverse economic climate enhances its difficulty, even failure in passage. This brief respite does **not** mean that organized medicine can allow its resistance to unfavorable legislative policies to slumber, but rather **ALL EFFORTS AND RESOURCES MUST INTENSIFY.**

A modality for action is membership in the Maryland Medical Political Action Committee. There are two types of membership. The first and most important is the category of Sustaining membership; the contribution for member and spouse is \$150. Another category is Regular membership; the contribution for member and spouse is \$45. It is apparent that the greater the contributions, the more effective your MMPAC will be.

Sustaining membership is a unique category. Its members generally tend to be more aware of the necessity of increased commitment. They realize that private medicine must release former restraints and flex its muscle. It must have input into the democratic processes.

Sustaining members are identified by the 99+ pin. Mailings include the Political Stethoscope Newsletter and a Sustainer Newsletter.

The Regular Membership has already grown into the thousands. Of this we are justly proud. The Sustaining members are as follows: (We urge you to join the list.)

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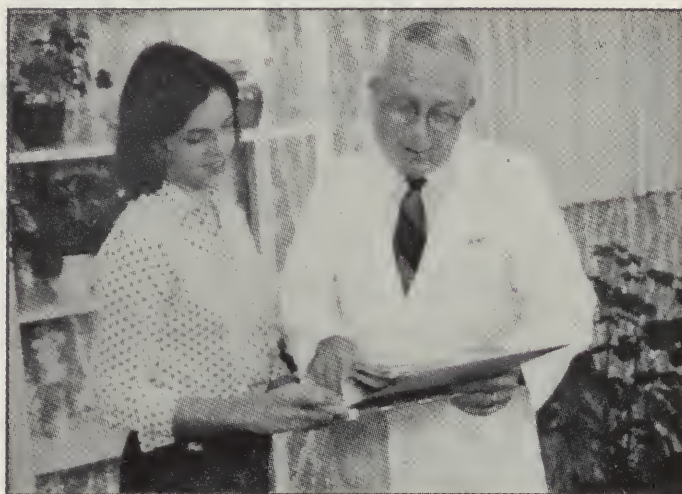


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CONRAD ACTON, MD, Editor

"A Slight Snow . . ."

Correction

(In the report of the October, 1978 Meeting, Dr. Harry F. Klinefelter is reported as saying that "Remissions are so frequent that it is difficult to determine whether any improvement is really due to the medication or would have occurred on its own." He actually made it quite clear that this was true only in the first six months and that if no remission has occurred *after* six months, it is unlikely that it will occur without treatment. The omission was inadvertent and is regretted.—CA.)

Because of "a slight snow" on Feb. 20, 1979, the Directors' regular meeting was held the following Tuesday.

PRC Reports

A report from the Professional Relations Committee indicated that in two instances, moonlighting interns had been employed by lay corporations under dubious circumstances. The Committee recommends that the BCMS make an effort to remind house officers to investigate prospective employers carefully before they become involved in what may be inappropriate activities. This could be done by reminding hospital administrators and chiefs of staff of their responsibility in this regard. The Committee feels that Residents should be particularly cautious about being employed by lay businesses which are relatively new.

Public Relations Committee

The Directors agreed with the first of two recommendations by the Public Relations Committee. Its Subcommittee on Cost Containment wants physicians to be more energetic in their efforts to reduce costs, both in their own offices and in their institutions. To this end, they recommend that the Newsletter have a regular column, a **Cost Containment Corner** for specific advice to physicians on how better to control medical care costs for their patients. A second recommendation, that the BCMS adopt the Primary Alcoholism Treatment Center and act as a facilitator in locating equipment and material from other segments of the community, was approved and referred back to the Public Relations Committee for implementation.

Snow Interviews . . .

Partly recovered from the February, '79 blizzard, faithful followers of the BCMS beat their way to the Hollyday Room for their regular, monthly meeting on March 1st. President Antlitz brought out the importance of our electing our **own** members to the Med-Chi Council. The BCMS worked hard—along with other component societies—to bring it about. This is the first year we can elect our own rather than have them se-

lected for us by the Council. Unfortunately, though the blizzard disrupted the delivery of mail to such an extent that many received their ballots **after** the voting deadline. Those ballots will be destroyed unopened and an entire, new mailing will be sent and is just as important.

Legislative Committee

The Legislative Committee, through Mr. Richard Rombro, brought news about the State Legislature's medical activities. Highlights include Amendments to the Podiatry Act to extend the scope of that practice and the Optometric Act doing the same for Optometrists.

The BCMS joined Med-Chi in opposing any extension of the Health Services Cost Review Commission's role to include physician's charges.

The perennial debate about who should **identify** specialists to the public in various listings, such as the **Yellow Pages**, is on again. That there are adequate **certifying** agencies is agreed, but since some physicians consider themselves specialists, and limit their practice but do not get themselves certified, a gap exists. Should this matter of **identification** be added to the Board of Medical Examiners domain? If so, what would be the legal consequences?

Other problems are: Whether a Health Maintenance Organization can be certified as such without an associated or back-up hospital? Should health research be done on inmates of State institutions? Should there be the possible abolition of the State Health Department Board of Review? And, finally, the ramifications of Hand-Gun Control measures?

Dr. Bormel

Paul Bormel, MD, President of the BCMS Foundation, invited us to the Foundation's dinner/dance celebrating Doctor's Day. He urged us all to come, bring guests and support the Foundation.

Dr. Nachlas Speaks

Marvin Nachlas, MD, spoke in opposition to the current socioeconomic phraseology of government regulations about the practice of medicine. He introduced a motion "That in all the general meetings of the BCMS, in its committee meetings, correspondence and publications, carefully-chosen words of known and clear meaning to the medical profession be used once again, and that the current ambiguous and fashionable terminology of the health care planners be assiduously avoided." He declared that "a health care provider was not necessarily a physician. It could be a paramed-

technician, nurse, pharmacist, dentist, podiatrist or optometrist—perhaps a chiropractor. Such phraseology makes patients into consumers, physicians into vendors, medical practice into health care delivery systems. After much discussion, the motion was adopted.

Dr. Siebens Talks

Arthur Siebens, MD, Professor of Rehabilitation Medicine and Director of Surgery of the Division of Rehabilitation Medicine at Johns Hopkins University and Hospital and Director of the Department of Rehabilitation Medicine at the Good Samaritan Hospital, presented the topic **Rehabilitation of the Severely-Neurologically-Traumatized Patient**. He reminded us first of all that trauma leads all causes of death in the 1-44-year age-group and that the trauma-disabled number 3-4 times the number of deaths. Conducting his "rounds" with colored slides, he graphically-illustrated the problems of tracheal stenosis, seizure control and differentiation and respiratory inadequacy, stressing that success has to be a team effort. The physician in this field must convince the patient that the prognosis is honest and often has to be content with limited gains. Accident prevention is better than treatment.

Directors Meet

Better weather prevailing, the Directors met March 20, 1979, their regularly-scheduled date. A letter from John King, Esq., our legal counsel, informed the Society that his former associate in BCMS affairs, Mr. Richard Bloch, would be replaced by Mr. King and Mr. E. Dale Adkins, III for the time being when legal advice is needed.

Howard A. Davidow, MD, Chairman of the Membership Committee, brought recommendations to the Directors. One was for presentation of Membership Certificates to new members when elected. The certificates would be suitable for framing and available to all members on request. Another Recommendation was in opposition to "unified" membership with the AMA. The Committee noted that this had been voted against at local and state levels in the past. A loss of memberships might follow compulsory unification.

A Motion adopted at the March General Meeting was considered. It opposed bureaucratic terminology for medical practice. Since the motion was enforceable only within our own Society, and since our staff, already very strict about its medical phraseology, needs no prodding, no action was taken at this time.

Charlotte Ferencz, MD, Professor at Maryland's Department of Epidemiology and Preventive Medicine, wrote the Society requesting financial support for student study fellowships. Such studies were supported by the Maryland Department of Health and Mental Hygiene, but discontinued a few years ago. This year, the Bureau of Health Manpower Apprenticeship Training's grant funding was stopped and is no longer available for this purpose. Such summer fellowship stipend is usually \$1,000 for the eight-week period.

The Directors decided they could not afford the added cost since a study of private practice profiles is already being sponsored. An alternate proposal within

BCMS scope was suggested for perhaps an annual prize for the best work done. It was further noted that such funding would be more appropriately sponsored by the older, established organizations such as the Heart Fund, Cancer Society, Christmas Seals and the like which have greater experience along these lines; after all, if the BCMS supports one worthy cause, it should support them all. The request was referred to the Committee on Public Education.

The pictorial **Register** of the members in 1975 was a success. Now it is proposed to bring it up-to-date with a new **Register**. The photographers who did the first one have offered a similar contract. The Directors agreed that it was appropriate to bring the **Register** up to date.

The Policy and Planning Committee recommends that the BCMS add to its member services by keeping a list of temporary secretarial help. The roster would be compiled from members who could give names of satisfactory past employees. The staff felt it would not involve serious additional work and would be a good list to have. The Directors went along with this.

Reports from the Health Care Delivery Committee and from the Legislative Committee were quite long. They were surveyed in detail. The Recommendations were generally concurred in.

"The burden grows . . ."

The scope of the **Monthly Newsletter** continues to expand. So far, the staff and Secretary Karl H. Weaver, MD have labored mightily and bring forth a fine publication, but the burden grows. The Board decided that an Editorial Board should be chosen to help with policy and production.

Boy Scout Time is here again. Sam O'Mansky, MD, Chairman of the Subcommittee to provide Medical Coverage for the Broad Creek Camp, wants volunteers to give one Sunday afternoon at the camp this summer. If you have the Heart to Help, call him at 661-2222 and get the date that suits you best to go there. It is a great project and a great day! ☐

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Our Emerging Technology—How Much is Enough?

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Executive Director's Newsletter

June, 1979

LEGISLATIVE

MEASURES

After July 1, physicians performing abortions will be required to inform the patient about available alternatives including financial assistance and adoption information. The Departments of Human Resources and Health and Mental Hygiene will develop the information. Patients will sign a document indicating the receipt of the information which will become part of the medical record. Failure to comply is subject to a fine of \$500.

All drugs dispensed privately by physicians except for emergency or starter doses will be required to be labeled with the name, dosage strength, expiration date and special handling instructions of the drug after July 1, 1979.

The generic drug law has been rewritten replacing the negative formulary with a positive one, removing the provision for the pharmacist to pass on the cost saving to the consumer, and removing any liability for substitution from the pharmacist.

NEW

Newly elected Faculty officers include the following:

FACULTY

President - William A. Pillsbury, Jr., MD, Lutherville
President-elect - Vincent J. Fiocco, Jr., MD, Westminster
Secretary - Bernard S. Karpers, Jr., MD, Baltimore
Treasurer - Robert B. Goldstein, MD, Baltimore

OFFICERS

Vice Presidents for the year are:

First Vice President - Donald J. Roop, MD, Towson
Second Vice President - J. Roy Guyther, MD, Mechanicsville
Third Vice President - Herbert H. Leighton, MD, Oakland

Council Chairman is Albert M. Antlitz, MD, of Baltimore, and Council Vice Chairman is J. Roy Guyther, M.D.

SECOND

OPINION

USE

Blue Shield of Maryland, Inc., has reported that a total of 15 calls have been made by its subscribers who are eligible for payment of second opinion services, since its inception several months ago. This is less than 1% of those eligible for this benefit who are utilizing it.

More details are not available at this time, such as whether or not such second opinion resulted in surgery, delayed surgery with surgery being performed at a later date, or no surgery at all.

PHYSICIANS'
COSTS AND
FEES

Physician Fee and Cost Indicators is included as an insert in the May 18, 1979 issue of AM NEWS. This booklet is an attempt by AMA to assist physicians in tracking costs and fees.

The first part of a dual system, the Physician's Fee Index (PFI) presents a method to measure the approximate overall rate of increase in your fees—for your information and for comparison with other economic gauges (such as the Consumer Price Index).

The second part, the Physician's Cost Index (PCI) provides a measure of the individual physician's rate of increase in direct and overhead expenses. This may help to identify the areas where cost increases appear out of line with general inflation.

If you have misplaced this insert, contact the Faculty office for a duplicate.

SEMIANNUAL
MEETING

Plans are now underway for the Semiannual Session to be held in New Orleans, Louisiana, September 12-16, 1979. Reservations for this meeting should be made through the Travel Guide Agency (Patricia Orem - 301-727-1811). Cost of the entire trip, including air fare, baggage handling, airport transfers in New Orleans, a welcome cocktail party, a breakfast at Brennans, and a farewell dinner - \$489 per person.

The House of Delegates session will be held in Baltimore at the Faculty Building on Saturday, September 29, 1979, commencing at 2 PM. The General Meeting of the Faculty will be held immediately following adjournment of the House.

Resolutions for consideration at the Faculty's Semiannual meeting of its House of Delegates must be in the Faculty office AT LEAST EIGHT WEEKS PRIOR TO THE DATE OF THE MEETING. This would mean that resolutions must be received prior to the close of business on

FRIDAY, AUGUST 3, 1979.


Executive Director

IMPAIRED PHYSICIAN'S HOTLINE - 301-467-4224

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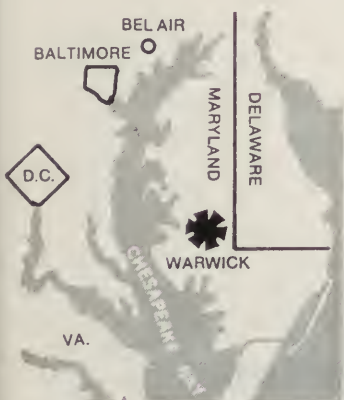


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The Library Page

Your Will Can Help

A major function of the Faculty, as defined in the charter given it by the Maryland Legislature in 1798, is to disseminate "medical and chirurgical knowledge throughout the state." The Medical Library is one means used by the Faculty to meet this charge. The Library's major function is to provide member physicians with timely and up-to-date information to assist them in their practice. In 1978, the Library answered almost 9,000 patient-care-related questions from Faculty members. Answers took the form of photocopied journal articles, bibliographies and loans of books; these services went to physicians in every part of Maryland, and almost all were transacted by mail or telephone.

Next year, the Faculty Library will celebrate its 150th birthday, and it is now more vigorous, more widely-used and more progressive than ever before. Past donations have made this development possible. Your additional support will enable the Library to broaden, strengthen and improve its services.

Including the Faculty Library in a will is one way Faculty members can show their appreciation for the services they have received from the Library. With such a bequest, the physician's lifework, dedicated to the care and healing of the sick, will be carried on by future physicians who will benefit from the bequest.

A bequest can take many forms, and the following information is not intended to be inclusive or to suggest the preparation of a will without the services of legal counsel:

1. An unrestricted bequest:

"I give and bequeath (\$.....) to the Medical and Chirurgical Faculty Charitable-Educational Foundation, Inc., for the use of the Faculty Library."

This bequest can be used by the Library for any purpose. Such funds are especially useful because they meet any needs that arise in the undisclosed future.

2. A bequest restricted as to principal, but not restricted as to income:

"I give and bequeath (\$.....) to the Medical and Chirurgical Faculty Charitable-Educational Foundation, Inc., for the use of the Faculty Library."

"The principal of this gift shall be held, and it may be mingled with other funds of the Foundation for investment. The income is to be expended for the benefit of the Library for any purpose."

(Optional provision: "This gift is made in memory of and shall

be known as the Fund.")

The principal of the money thus given creates a permanent fund. This form of gift is especially suitable for endowments, since the income is available at any time for any urgent need.

3. A bequest to be held as a permanent fund, the income to be used for a special purpose:

"I give and bequeath (\$.....) to the Medical and Chirurgical Faculty Charitable-Educational Foundation, Inc., for the use of the Faculty Library. The principal of this gift shall be held, and it may be mingled with other funds of the Foundation for investment. The net income shall be used to: (here describe the primary intended purpose, such as: the purchase of books and journals in a particular field of medicine, e.g., obstetrics; to provide for the salary of a librarian; to purchase audiovisual equipment for continuing medical education; etc.)

(Optional provision: "This gift is made in memory of and shall be known as the Fund.")

Money given in this way establishes a permanent fund, which is a most satisfactory memorial gift. The primary purpose for which the income should be spent is usually one of special interest to the donor and one that he believes will be especially useful for the Faculty Library.

The following provision may be added to a bequest

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to members of Med-Chi during the month of March, 1979:

1. Intelligence testing in Europe	40	citations
2. Amyloidosis and the larynx	12	"
3. Alcoholism and the college student	20	"
4. Surgery for scoliosis	54	"
5. Chlamydia infections in infants	40	"
6. Management of achalasia	14	"
7. Controlling fever in children	40	"
8. Digitalis glycosides poisoning	32	"
9. Chromium levels in the blood	10	"
10. Compulsive gambling	10	"

If you would like a copy of one of these searches, or would like to have a search on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
Assistant Librarian

in the form of 2 or 3: "If it is found by the Library Committee that all or part of the income cannot be used to the best advantage for the above purpose, then all, or any balance of the income not so expended, may be used for any purpose that is within the corporate powers of the Faculty and approved by the Library Committee."

This paragraph, sometimes called an "escape clause," allows for unexpected changes in conditions that may occur over a long period and may make it unwise, or even impossible, to continue to apply all or any of the income to the primary purpose. With this "escape clause," income that cannot be wisely-spent for the primary purpose will be spent for some other useful end.

Taxes

Under the present law, bequests made to the Faculty Library in any of the foregoing forms are fully-deductible in computing the net estate of the testator, subject to the Federal estate tax. The law of the state where the donor resides at the time of his or her death determines the extent to which the bequests are deductible from state and inheritance taxes. A deduction in computing the Federal estate tax is often very valuable; in the case of a large estate, the deduction of a bequest may reduce the Federal estate tax by more than half the value of the gift.

For more information regarding the inclusion of the Faculty Library in your will, and for suggestions as to needs of the Library that would be helped by a bequest, contact the Faculty Librarian.

JOSEPH E. JENSEN
Librarian

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New Book Titles

Anesthesia

- QV Cohen, Ellis N., 1909-
81 **Metabolism of Volatile Anesthetics: Implications for**
.C 678m **Toxicity.** Reading, MA, Addison-Wesley Pub. Co.,
1977 1977.
WO Internatl. Symposium on Malignant Hyperthermia, 2d
245 Denver, 1977.
.I 61s **The Second Internatl. Symposium on Malignant Hyper-**
1977 **thermia.** New York, Grune and Stratton, 1978.

Cardiovascular System

- WG **The Heart, Arteries and Veins.** 4th ed. New York, Mc-
100.3 Graw-Hill, 1978.
.H 436
1978
WG Johnson, Paul Christian, 1928-
106 **Peripheral Circulation.** New York, Wiley, 1978.
.J 68p
1978

Critical Care

- WX **Critical Care Med. Manual.** Ed. by Max Harry Weil,
218 Protasio L. Daluz. New York, Springer-Verlag, 1978.
.C 936
1978

Delivery of Health Care

- W Constantine, James M.
74 **Health Care Expenditures in the Central MD Health**
.C 757h **Service Area Fiscal Year 1976.** Balto., MD, Central
1979? MD Health Systems Agency, Inc., 1979?

Echocardiography

- WG Kleid, Jack J., 1937-
141.5 **Echocardiography: Interpretation and Diag.** New York,
.E 2 Appleton-Century-Crofts, 1978.
.K 63e
1978

Emergency Care

- WX Grant, Harvey, 1934-
215 **Emerg. Care.** 2d ed. Bowie, MD, Brady, 1978.
.G 762e
1978

Fetal Alcohol Syndrome

- WQ US Congress. 95. 2nd Session.
211 **Alcohol Labeling and Fetal Alcohol Syndrome, 1978.**
.U 58a Wash., DC, GPO, 1978.
1978

Headache

- WL Diamond, Seymour, 1925-
342 **The Practicing Physician's Approach to Headache.** 2d
.D 537p ed. Balto., Williams and Wilkins, 1978.
1978

Hospitals

- WX Amer. Coll. of Hosp. Administrators, **Code of Ethics,**
150 Chicago, IL, 1976.
.A 512c
1976
W **Physician Compensation.** Ed. by David T. Pieroni. Ger-
79 mantown, MD, Aspen Systems Corp., 1978.
.P 578
1978

Hypothalamus

- WL **The Hypothalamus.** Editors: Seymour Reichlin, Ross J.
312 Baldessarini, Joseph P. Martin. New York, Raven
.H 9988 Press, 1978.
1978

Medical Education

- W Hubbard, John Perry, 1903-
18 **Measuring Med. Educ.: the Tests and the Experience of**
.H 875ma **the Natl. Board of Med. Examiners.** 2d ed. Phila.,
1978 PA, Lea and Febiger, 1978.

Medicine

- WB **Price's Textbook of the Practice of Med.** 12th ed. Ed.
100.3 by Ronald Bodley Scott, Oxford, NY, Oxford Univ.
.P 945 Press, 1978.
1978
WB **Davidson's Principles and Practices of Med.: a Text-**
100 **book for Students and Doctors,** 12th ed. Ed. by John
.D 252 Macleod. Edinburgh, New York, Churchill Living-
1977 stone, New York: distrib. in the US by Longman,
Inc., 1977.

Neoplasms

- QZ Lokich, Jacob J., 1938-
266 **Primer of Cancer Management.** Boston, Hall, 1978.
.L 836p
1978
QZ Pitot, Henry C., 1930-
200.3 **Fundamentals of Oncology.** New York, Dekker, 1978.
.P 685f
1978

Occupational Diseases

- WA Hunter, Donald
400 **The Diseases of Occupations,** 6th ed. London, Hodder
.H 945d and Stoughton, 1978.
1978

Ophthalmology

- WW Newell, Frank Williams, 1916-
100.3 **Ophthalmology: Principles and Concepts.** 4th ed. St.
N 544o Louis, Mosby, 1978.
1978
WW Havener, William Henry, 1924-
166 **Ocular Pharmacology.** 4th ed. St. Louis, Mosby, 1978.
.H 386o
1978
WW Walsh, Thomas Joseph, 1931-
141 **Neuroophthalmology: Clinical Signs and Symptoms.**
.W 227n Phila., PA, Lea and Febiger, 1978.
1978

Pathology

- QZ Peery, Thomas Martin, 1909-
4.3 **Peery and Miller's Pathology: a Dynamic Intro. to**
.P 375p **Med. and Surgery.** 3d ed. Boston, Little, Brown,
1978 1978.

Pediatrics

- WS Johns Hopkins Hospital, Baltimore. Children's Med.
29 and Surgical Ctr., Harriet Lane Service.
.J 65h **The Harriet Lane Handbook, a Manual for Pediatric**
1978 **House Officers.** 8th ed. Chicago, Year Book Med.
Publishers, 1978.

- WS **Current Ped. Diag. and Treatment,** 5th ed. By C. Henry
141 Kempe, Henry K. Silver and Donough O'Brien. Los
.C 976 Altos, CA, Lange Med. Pub., 1978.
1978

Rheumatic Diseases

- WE **Copeman's Textbook of the Rheumatic Diseases,** Edited
140 by J. T. Scott. 5th ed. Edinburgh, New York,
.C 748 Churchill Livingstone, New York, distributed in the
1978 US by Longman, 1978.

Spinal Disorders

- WE Harris, John H., 1925-
725 **The Radiology of Acute Cervical Spine Trauma,** Balti-

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- .H 314r more, Williams and Wilkins, 1978.
1978

- WL **Spinal Angiomas: Advances in Diag. and Therapy,** Ed.
400 by H. W. Pia and R. Djindjian. Berlin, New York,
.S 757 Springer-Verlag, 1978. ☐
1978

Coming in the Journal:

Quality of S as an Indicator of Left Ventricular Performance

by William F. Renner, MD and

Fat Embolus

by Timothy A. Lamphier, MD



"You'll have to give up wine and women, Mr. Davis, but sing all you want to."

Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL, as cases become final.

IN THE MATTER OF DONALD EDGREN, MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Upon certain information coming to its attention, pursuant to Article 43, Section 130 of the Annotated Code of Maryland, the Commission on Medical Discipline initiated an investigation into the medical practice of the Respondent, Donald Edgrin, MD. Therefore, the Commission determined to charge the Respondent with certain violations of the Code. The violations charged involved the following subsection of Article 43, Section 130 (h):

(18) Professional and mental incompetence.

Appropriate notice of the charge and the grounds from which it arose was given to Respondent and a hearing to consider said charge was scheduled before the Commission on May 16, 1978. Prior to the date of the hearing, conversations took place between Richard Kovelant, Esq., counsel for Dr. Edgrin, and Stephen J. Sfikas, Assistant Attorney General, counsel to the Commission, concerning the possibility of reaching a mutually-agreeable consent decree. As a result of those conversations, and other discussions, consultations, physicians' reports and findings, the Commission has determined to enter into the following Consent Order with the Respondent.

FINDINGS OF FACT

The Commission finds:

1. That the Respondent's mental condition has interfered with his ability to practice medicine in a competent fashion.
2. That the Respondent has undertaken on his own, to seek psychiatric assistance and the Respondent has indicated his willingness to continue under psychiatric treatment and to submit to regular peer review of his practice.
3. While acknowledging the validity of the Order, the Respondent does not concede the validity of the charges against him or the correctness of the Commission's Findings of Fact or Conclusions of Law.

CONCLUSIONS OF LAW

Upon the foregoing Findings of Fact, the Commission concludes as a matter of law that due to the Respondent's mental condition he was not capable of the competent practice of medicine and the Commission adjudicates the Respondent GUILTY of mental incompetence.

ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 16th day of May, 1978, by the unanimous vote of the Commission on Medical Discipline

ORDERED that the license to practice medicine in the State of Maryland previously issued to Respondent be, and the same is hereby SUSPENDED for a period of two years from the date of this order; and be it further

ORDERED that this Suspension be STAYED with Respondent placed on PROBATION upon the following terms and conditions:

- 1) That the Respondent continue in a program of psychiatric treatment with a psychiatrist acceptable to the Commission;
- 2) That the Respondent and his psychiatrist shall have at least one psychiatric session every other week, or as otherwise directed by his psychiatrist;
- 3) That the Respondent's psychiatrist shall report to the Commission on a quarterly basis as to the Respondent's progress in treatment.
- 4) That the Respondent shall make satisfactory progress in his course of treatment;
- 5) That the Respondent's treatment shall continue until such time as the Commission, in consultation with Respondent's psychiatrist, shall determine that psychiatric treatment is no longer necessary;

6) That the Respondent shall submit to peer review by the Commission or its agents on a monthly basis;

7) That the Commission's agent shall provide the Commission with reports as to the quality of the Respondent's practice;

8) That the Respondent's practice shall be in accord with those standards expected from a competent practitioner of medicine in the State of Maryland; and be it further

ORDERED that each year from the date of this Order the Commission shall review the terms of this Order to determine what, if any, modification might be appropriate in light of the Respondent's progress, provided however Respondent can be permitted to petition for earlier review; and be it further

ORDERED that if the Respondent has demonstrated a cure for his illness and satisfactory practice, three years following the date of this Order the Commission shall terminate Respondent's probationary status and upon such occurrence this Order shall be of no further effect, provided that the Commission may in its discretion terminate Respondent's probationary status sooner than three years if the Commission is satisfied with his progress; and be it further

ORDERED that should Respondent violate any of the foregoing terms and conditions, upon notification by and a hearing before the Commission, the Stay of Suspension shall be withdrawn and Respondent's license shall be SUSPENDED for two years; and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners in accordance with the Annotated Code of Maryland, Article 43, Section 130 (m).

JOHN E. ADAMS, MD

Chairman

Commission on Medical Discipline of Maryland

CONSENT

By this Consent, I hereby accept and submit to the foregoing

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Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony and to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation, I may suffer the suspension of my license to practice medicine in Maryland.

Although I recognize the validity of this Order and consent to its terms, I do not admit to the validity of any of the charges against me or to the correctness of the Commission's Findings of Fact or Conclusions of Law.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

DONALD EDGRIN, MD
STATE OF MARYLAND

I HEREBY CERTIFY, that on this 16th day of May, 1978, before me, the subscriber, personally appeared DONALD EDGRIN, MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

ARLINE JOHANSEN
Notary Public



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Medical Miscellany

Mathias says President's 1980 Budget Gives National Institutes of Health "A Raw Deal"

Sen. Charles McC. Mathias, Jr. (R,MD) says the National Institutes of Health have been given "A raw deal in the President's 1980 budget."

In a recent address to the Annual Meeting of the Interassembly Council of Scientists of the National Institutes of Health at Bethesda, MD, the Maryland senior Senator declared: "In absolute terms, the Administration's fiscal year '80 budget request for NIH of \$3.172 billion is slightly below the FY '79 budget, and if you figure in the toll inflation takes, it is well below the FY '79 level."

"Last week we heard testimony in the Senate Labor HEW Appropriations Subcommittee forecasting that the new NIH budget means about an 8% cut in research funds."

"I think that estimate is conservative. I think the cut will be much higher than that unless we do something about it."

According to Sen. Mathias, "One of the most short-sighted aspects of the President's FY '80 budget request is his proposal to rescind the \$37 million Congress appropriated last year for a new building for the National Institute of Child Health and Human Development. I would hate to have to choose between competing research priorities, but certainly a good case can be made for giving priority to programs directed at improving child health."

Biomedical research, the Senator emphasized, "Should be right up with defense at the top of any list of national spending priorities . . . Obviously, one of the most unproductive ways to respond to Proposition 13 pressure for economy in government would be to short-change biomedical research. The one sure way to make

this country go broke is to send more people to the hospital, and one sure way to balance the budget is to find ways of preventing disease."

He also stated: "You can almost prove mathematically that for every dollar spent by NIH, society will save \$20 in reduced health care costs and increased human productivity."

"We've got a fine example of cost-effectiveness in the health field here in Maryland in our very successful immunization campaign against measles. In 1976, the State registered 718 cases of measles; in 1977, the number of cases was down, but still too high, at 399 cases but last year, as a result of the nationwide effort to immunize children initiated by the Center for Disease Control, Maryland registered only 51 cases of measles. This program has more than justified itself in terms of dollars and cents savings. When you factor in the human agony avoided, the lowered incidence of birth defects, of deafness and blindness, the savings are literally incalculable."

"I have also been very impressed by the statistics the National Cancer Institute has produced showing that the economic loss to the nation because of cancer is between \$15-\$25 billion annually. Beside those figures \$3 billion seems, and is, ridiculously little to spend on biomedical research."

"Every time we get a new OMB director, I make the same pitch. I've recommended to all of them that they visit NIH and see what a tremendous asset they have in this operation. I tell them you've got four Nobel laureates out here and 14 more associated with NIH but even that doesn't tempt them to lay aside their pruning shears long enough to take a look at an operation that really saves them money. Not one OMB Director in the lot has even responded to my invitation. Mr. McIntyre, at least, promised me that he would make an official visit to NIH, but I'm still waiting for him to keep that promise. I hope he will. It would be an eye-opening experience for him."

"Of course, no one really needs to come out here to find out that we're getting a high return on the money we've invested in biomedical research. You can learn that just from reading the newspapers. The data on the dramatic decline in the stroke death rate released by the National Heart, Blood and Lung Institute two weeks ago speaks for itself. A 36% decline in the stroke death rate since 1962 is a handsome return on our investment by any standard. I congratulate you on another job well done, but, although I rejoice along with everyone else when you produce a major breakthrough of this sort, I don't clamor for quick results. I know that it takes many years for basic research to have its full impact, and the results are well worth the wait. As the policymaking board of the National Science Foundation recently pointed out to President Carter: "One third of the growth in the national income during the postwar period flowed from advances in knowledge particularly in the sciences and the new technologies to which they give rise. This is a peerless record." □



SEN. MATHIAS

Coming in the Journal:

Doctor vs. Lawyer: Why It Cannot Be Done in Maryland
by John F. King, Esq. and M. Bradley Hallwig, Esq.

Medical Records Safeguards Proposed in Privacy Amendment

Warning that widespread use of computers poses a threat to the privacy of Americans, US Senator Charles McC. Mathias, Jr. (R-MD) recently proposed legislation to protect a patient's medical records from unwarranted scrutiny.

Mathias joined other Senators in cosponsoring an amendment to the Privacy Act of 1974. The bill, Mathias said, "Strikes the proper balance between the legitimate needs of certain public and private organizations to have access to medical records, and the individual patient's rights to privacy."

The bill's most important feature, he said, corrects a situation in which a patient is often the one person who cannot see his medical record. Under the bill, patients would have the right to see their records and to correct a portion of a record they feel is wrong.

In those instances where the health facility declines to show the patient his record because this would be harmful to him, the patient would have the right to appoint a representative to see the record.

In general, the bill would require that a patient give his consent before his medical record could be disclosed to a third party, but it also provides for what Mathias called "reasonable disclosures" without the patient's consent—for example, to employees, auditors and others who work with the health provider, and to rescue workers in the event of a medical emergency. Where a law enforcement agency seeks access to a patient's record by subpoena, the agency generally must notify the patient to give him a chance to contest the action.

The bill's provisions would cover hospitals, nursing homes, clinics and other institutions that participate in Medicare and Medicaid. Physicians who practice in groups of two or more would also be covered, but the individual family doctor would be exempt. "In most cases, his own discretion and his close relationship with his patients are sufficient assurance that their privacy will be respected," Mathias said.

Mathias said the legislation "Is essential to assure that the protections we require as a free people are provided by all institutions. The sanctity of medical records must be preserved if another one of our precious freedoms is not to be whittled away." □

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by Jesse Rubin, MD



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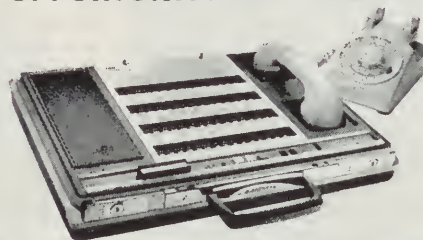
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Doctors Take Note

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All classes, talks, etc. held in Rm. 101, Ross Hall, GWU Sch. of Med. and Health Sci., 2300 I St., NW, Wash., DC. For details, call Dr. Arthur St. Andre at (202) 676-2821. All talks on Weds. evenings, 6:30-8:30.

June 13, Renal: Tubular Dis. incl. Acute Renal Failure, talk by Anne Thompson, MD, at 6:30, followed by **Chronic Renal Failure, Transplantation**, at 7:30 PM.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

June 14-15, Current Drug-Use in Pregnancy.

June 14-15, Occupational Health.

July 11-13, 12th Miles Internatl. Symp., Polypeptide Hormones. Chairman: Roland F. Beers, MD, PhD. For details, write or call Edw. G. Bassett, PhD, Symposium Coordinator, Miles Labs, Inc., PO Box 40, Elkhart, IN 46515; (219) 264-8460.

July 23-27, Educ. Diag. in Pub. Health and Med. Care.

By Appointment, Practical Computer Reporting in Rad.

On-going (Home Study) Postgrad. Course in Intern. Med.

Seven Symposia (Home Study) Highlights of the Topics in Clin. Med.

(Home Study) Echocardiography: Theory and Practice.

On-going Grand Rounds and Clin. Confs.

(Johns Hopkins, Baltimore City and Good Samaritan Hosp.)

The Hopkins Med. Insts. Dept. of Rad. and Rad. Sci. offers several courses in abdominal and obstetrical ultrasound. A Basic Practicum for the novice ultrasonographer is given every other month. Three times a year, an Advanced Practicum for the physician who has had at least six months' ultrasound

experience is offered. A Visiting Physician's Course is offered weekly throughout the year for "hands on" experience in the lab and participation in reading sessions. Fee for all courses is \$400. Cat. I Credits are available. For more details, please contact Joan Batt, Dept. of Rad., Johns Hopkins Hosp., Balto., MD 21205; or call (301) 955-8450.

Taylor Manor Hospital

For details, contact Frank J. Ayd, Jr., MD, Taylor Manor Hosp., Ellicott City, MD 21043, or call (301) 465-3322.

June 20, Psychopharmacotherapy Update, talk by Frank J. Ayd, Jr., MD, Dir. Prof. Educ. and Research, Taylor Manor Hosp. and Clinical Professor, Dept. of Behavioral Med. and Psych., WV Univ. Med. Ctr., Charleston, WV.

University of Maryland

June 15-16, Symposium on Head and Neck Carcinomas. For more data, call (301) 528-3956.

June 21-23, Dermatology Days. Call above number for details.

Other Maryland Meetings

An **Alcohol Education Course** is offered free to the public each Wednesday evening throughout the year by Sheppard Pratt Hospital in Towson, MD. The weekly sessions are held at 7 PM in Rm. 305 of the Hospital's Central Building. The course is designed to increase public awareness about alcohol use and abuse, and alcohol-related problems, and is under the direction of Dick Prodey. The full series runs for nine weeks, but since each session is a complete unit, attendance can begin at any point and then continue for eight consecutive weeks. The course includes lectures and the use of audio-visual aids, with ample time reserved for discussion and questions by participants. The program provides an excellent opportunity to learn more about this important social issue, and interested persons are cordially invited to join the group. For further info., please contact the Hospital's Office of Public Information, (301) 823-8200, exts. 247 or 257.

June 13, 8th Annl. Membership Buffet-Supper Mtg. and Volunteer Awards Presentation of Central MD Chapter, Amer. Heart Assn., 17 E. Mt. Vernon Pl., Balto., beginning 6 PM. For details, call (301) 685-7074. □

Doctors in the News

Programs on Early Years at Hopkins

Two programs of informal memoirs on the early years at Hopkins and some of the doctors who helped shape the institution were presented by the Johns Hopkins Medical History Club recently in the Doctors' Dining Room of the Hospital.

One focused on Dr. William H. Welch, first fulltime member of the Johns Hopkins medical faculty, one of the academic architects of the School of Medicine, and the first Director of the School of Hygiene and Public Health. Dr. Vic-

tor A. McKusick, Director of the Department of Medicine, introduced a film of Dr. Welch, and comments were given by Dr. George W. Corner, Professor Emeritus of Embryology, and former Executive Officer of the American Philosophical Society. Dr. Corner's many scientific achievements include the discovery of the hormone progesterone.

Attention was also turned to Hopkins in the 1920s. Dr. Thomas B. Turner, Dean Emeritus of the medical faculty, introduced a film of Dr. J.J. Abel, first Professor of Pharmacology at Hopkins, describ-

ing his development of the artificial kidney. Reminiscences of Dr. Abel and other leading figures of the Hopkins faculty were given by Drs. Warfield M. Firor, Richard W. TeLinde and Charles W. Wainwright, Professors Emeriti of Surgery, Gynecology and Medicine respectively.

The programs were cosponsored by the Medical History Club and by the Committee on Cultural and Social Affairs.

Dr. Rappeport Named

The American Board of Forensic Psychiatry, Inc., at the recent meeting in Los Angeles, announced that Dr. Jonas R. Rappeport of Baltimore has been named a certified Diplomate in Forensic Psychiatry.

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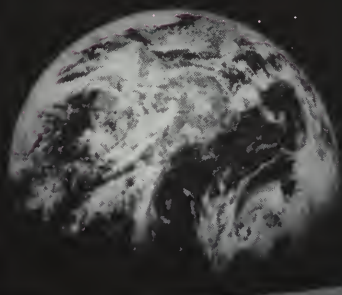
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Medical Miscellany

South Baltimore General Hospital Dedicates Herman L. Gruehn Building

Dedication ceremonies for South Baltimore General Hospital's Herman L. Gruehn Building were held recently on the hospital grounds overlooking Baltimore's waterfront (see picture below.)

The new, five-story, \$5.3 million building provides space for the Hospital's licensed School of Practical Nursing, housestaff quarters, in-service educational facilities, offices for nearly 20 private physicians and a 200-seat educational auditorium for the continuing education of the attending Medical Staff.

It also completes the Hospital's original design capacity of 534 beds.

The Building is named in honor of Herman L. Gruehn, a Past President of the Hospital's Board.

Mr. Gruehn was instrumental in the enactment of the Maryland Hospital Loan Act of 1964, which enabled numerous hospitals, including South Baltimore General, to expand or replace outmoded facilities and provide expanded health services to the citizens of Maryland.

He also was chairman of the special blue ribbon Commission to Study Hospital Costs appointed by then-Gov. J. Millard Tawes in 1964.

In 1970, Gruehn helped write the formula for a State regulation which led to the creation of the Hospital Services Cost Review Commission.

Notice to All Physicians

The private physician being one of the major source who refers patients to the John F. Kennedy Institute in Baltimore, let it be known to all concerned that the Kennedy Institute complies with Title VI of the Civil Rights Act of 1967 in that all admissions, treatments and accommodation assignments, to both inpatient and outpatients, are made without regard to race, color, creed or country or national origin. Furthermore, no applicant for employment, both professional and non professional, shall be denied employment on the basis of sex, race, age, creed, color, nor handicap in any job for which he or she is qualified. ☐



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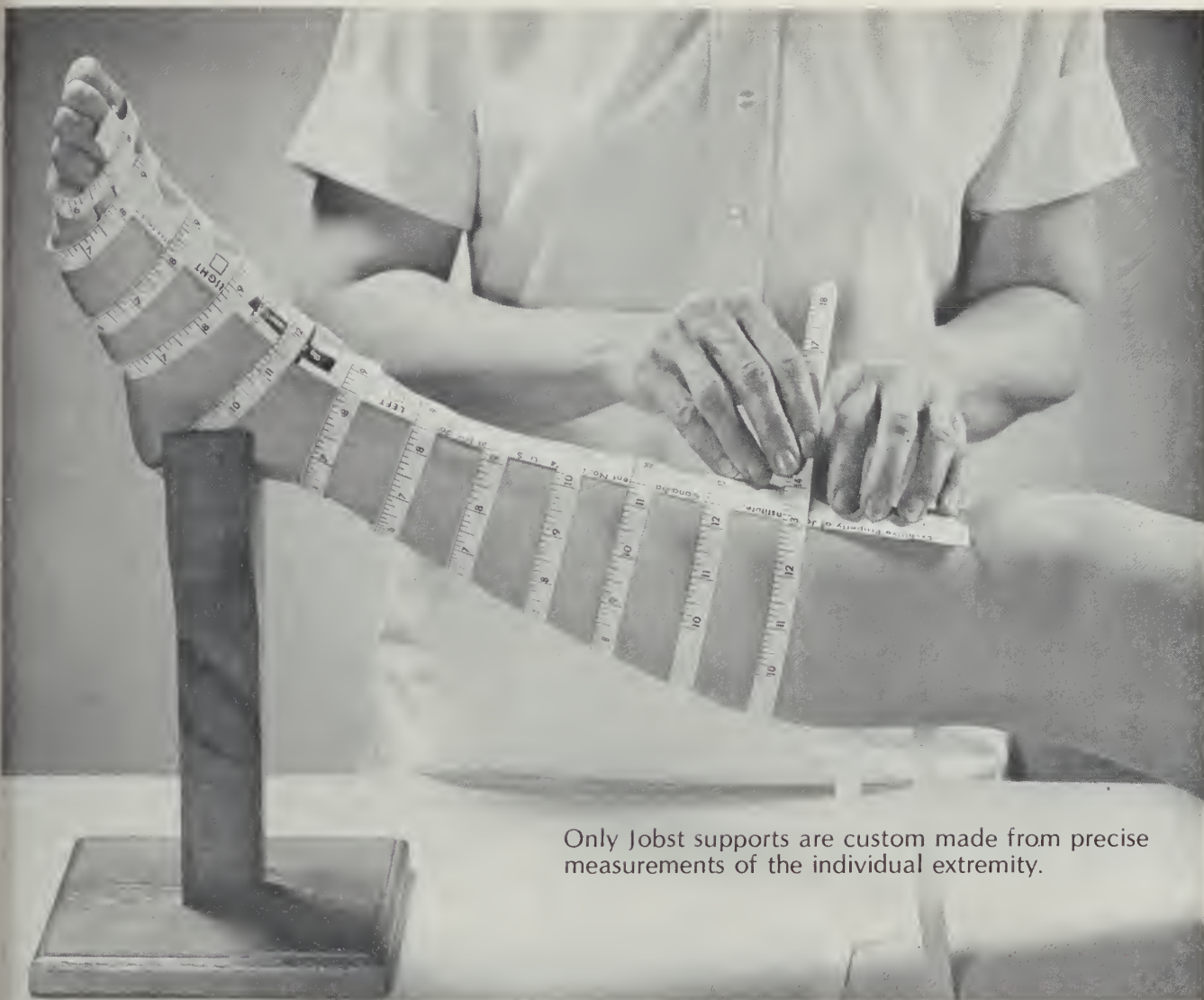
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Doctors in the News

Dr. Tabatznik Speaks to Cardiology Conference

Dr. Bernard Tabatznik, chief of the Department of Cardiology at North Charles General Hospital, addressed the cardiological department conference recently in the Hospital's William Schuman Lecture Hall at Charles and 28th



BERNARD TABATZNIK, M.D.

Streets in Baltimore.

The subject of the conference was Synscope.

Dr. Stephen P. Cohen Appointed Urologist-in-Chief at Sinai

Dr. Stephen P. Cohen has been appointed Urologist-in-Chief at Baltimore's Sinai Hospital, it was announced recently by **Spencer Foreman, MD**, Executive Vice President. Dr. Cohen succeeds **Dr. Martin A. Robbins**, who had served as head of the Department since 1961. Dr. Robbins continues in private practice.

Until his appointment, Dr. Cohen had served as Associate Chief of Urology at Sinai. Prior to that, he was Chief of the Division of Urology at North Charles General Hospital, also in Baltimore.

Born in Patterson, NJ, Dr. Cohen received his bachelor's degree from Middlebury College in Vermont and his Medical Degree

from the University of Maryland School of Medicine. He served both his internship and residency at Sinai and has been an active member of its medical staff since then.

A member of many professional societies and the author of several medical papers, Dr. Cohen is certified by the American Board of Urology. He is President of the Maryland Urological Society.

"Parental Burn-Out" Discussed

The St. Agnes Hospital Department of Pediatrics in Baltimore recently held evening class and discussion for the parents of children with learning and behavior problems. The topic of discussion was **Parental Burn-Out**.

All interested persons, including teachers, nurses, physicians, neighbors and friends were invited to attend the free class.

Participating in the discussion were members of the St. Agnes Hospital staff: **Dr. Gregory Fernando**, Child Psychiatrist, and **Dr. Anil Kumar**, Pediatric Fellow, Ambulatory Care and School Health Program.

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Ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Each gram contains: Neosporin[®] (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically*, (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyoderma (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the

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The tranquilizer component alleviates symptoms of anxiety and agitation within a few days, without apparent dulling of mental acuity. Hypnotic effects from the tranquilizer component appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

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Treatment with TRIAVIL—a balanced view:

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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TRIAVIL® 4-25: Each tablet contains
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TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effectively antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia. Antiparkinsonian agents usually do not alleviate the symptoms. It is advised that antipsychotic agents be discontinued if the above symptoms appear. If treatment is instituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbance (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitation; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia, and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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Run—and Don't Look Over Your Shoulder, Part 2

By PHILIP F. WAGLEY, MD

For reprint and other data contact Dr. Wagley at 9 E. Chase St., Balto., MD 21202.

The first article of this series presented a rather panoramic view of certain aspects of running.¹ The current piece supplements that approach. For example, one "rule" has been given about speed of running. Another "rule" frequently used is defined as follows:² If one subtracts one's age from 220 and multiplies the difference by .70 and by .85, one obtains two figures. These are considered as defining the pulse range one should attain in running. For a person of 60, this would be between 112 and 136. A lay person may find this most easily—determined by palpating the carotid instead of the radial artery. A few determinations suffice in providing general guidelines as to how much faster or more slowly one should jog on various terrains. A physician should emphasize the added strain on a runner of a facing wind, the early postprandial period and slight inclines. Any irregularity of the pulse noted during such determinations should be reported. A distance runner develops at rest a slow pulse—not infrequently below 50.

Metabolic Changes

"Interval running" is a frequently-used form of training. There are many variations of this, but the principle is always the same—short bursts of speed alternating with a slow jog for a recovery period. It is in this framework of training where estimation of the pulse range is important. Anaerobic exercise is alternated with aerobic recovery. During the latter the oxygen deficit decreases. As shown in Figure I in the first article¹ one's ability to metabolize lactic acid can be improved with physical training. Such interval spurts are not done while one is running a long distance. In other words, "interval running" should be practiced when shorter daily distances are covered.

Once a week a serious marathoner, while training, may do a "depleting" run. This is a significantly-longer run, one he could not do day after day. In preparation for competitive distance running, a "depleting" training run may be followed by a change in diet, such as a high carbohydrate "loading" diet. The reasoning for this is mentioned below.

In addition to reasons previously given for early morning running, there can be added that of an "empty stomach." Waiting as long as three hours after a meal and then attempting to run impresses one as being quite different than running after an overnight fast. Following the shorter postprandial interval, one's stamina is much less.

It is a surprise to some that running actually suppresses one's appetite. In other words, early morning runs do not lead to any desire for a large breakfast but, on the contrary, decrease one's hunger. Various estimates have been given as to the caloric expenditure by different exercises for certain durations;³ however, reference to suppression of hunger by strenuous activity is not emphasized. This appetite suppression may have an even more significant role in weight-reduction than the rapid expenditure of calories.

There is a degree of fuel "homeostasis" in exercise.⁴ At rest, muscles are dependent primarily on oxidation of fatty acids. With exercise, as oxygen need increases, the skeletal muscles use glycogen as well as more free fatty acids (FFA). During the first few minutes of activity, glycogenolysis increases. With continued exercise, blood-borne substrate is required. Under these circumstances, blood glucose uptake may increase 10-20 times the basal level; however, this accounts for only 30-40% of the total oxygen consumed by the exercising muscle. An additional 40% or more is needed for oxidation of fatty acids. The total body turnover of glucose with severe exercise may increase five fold.⁴ As strenuous contractions continue, the oxygen utilization by glucose rises, but is exceeded by even more free fatty acid (FFA) substrate. This is illustrated in Figure I (this article) based on data by Ahlborg, Felig et al.⁵ Muscle glycogen values in a rested marathoner have been reported two-three times the level found in untrained

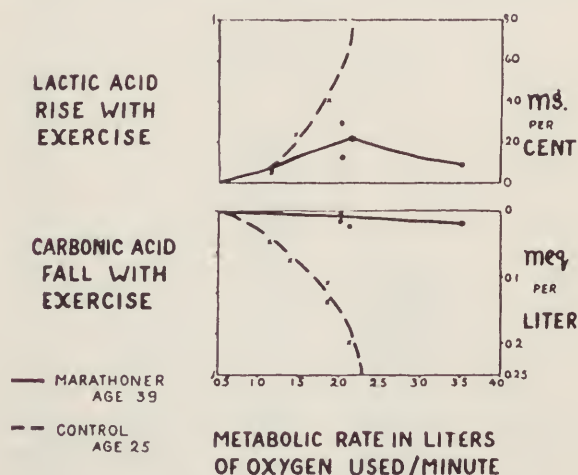


FIGURE 1 (from July, 1978 *Journal* article, Part 1): Change in the Blood Lactic Acid and Carbonic Acid Plotted after Various Degrees of Physical Effort as Determined by the Oxygen Consumption in Liters Used per Minute. The lack of much change in either blood lactic acid or carbonic acid in the case of DeMar, the marathoner, is to be contrasted with a "control" 25 years of age. Data reported by Bock and Currens and White. Modified presentation of data.

muscles.⁶ It is on this basis that carbohydrate “loading” or “packing” is practiced.⁷ (The historical background and the pros and cons of such dietary management will be discussed in a later paper.)

Musculoskeletal Problems

The literature on running contains much about musculoskeletal problems. The knees, ankles and feet seem to be vulnerable and limiting factors frequently. Interestingly, the hip joint is mentioned relatively rarely. Although one thinks of all these joints as weight-bearing articulations, it is obvious the hip bears significantly-less weight than do the others on impact. The leg itself makes up a high percentage of the total body weight. In jogging, each hip is spared on impact the weight of its “own” leg, so to speak.

Because a run of one or two miles sometimes seems needed to “loosen up,” much emphasis is given to preliminary stretching exercises. The author thinks there are limitations to such, however. Some are really contortions with joints placed in extreme positions. The would-be-runner then stretches from such positions with body weight being moved forcefully. Such stretching can be painful and possibly harmful. Most such exercises are to stretch the hamstring and gastrocnemius soleus muscles. One simple exercise that seems safe when done slowly is to stand facing a wall (and far enough away to barely touch it) with extended arms. One then slowly leans toward the wall as closely as possible, keeping the feet flat on the floor. A practical outdoor variation is to lean against a car or post and move the legs back, keeping the feet flat on the ground. This can and should be done repeatedly. It avoids the lunging and jerking effects one witnesses so often when people stretch by flexing at the waist or by kicking their feet upward.

A frequent site of discomfort with running is the

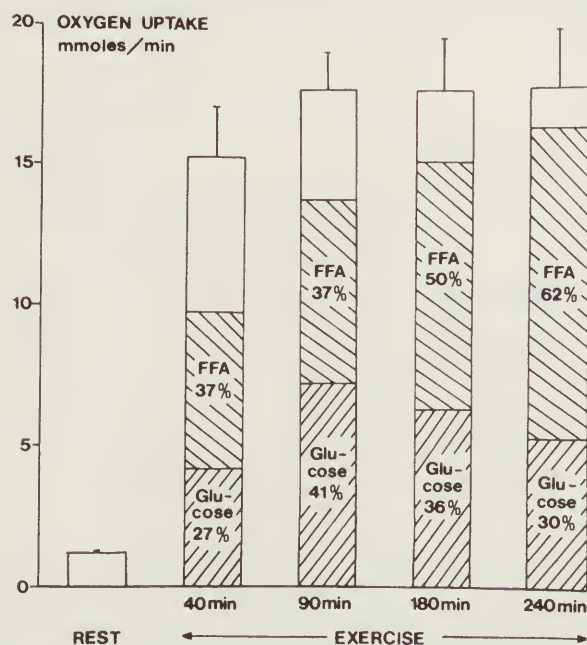


FIGURE 1 (current piece): Uptake of oxygen and substrates by the legs during prolonged exercise (reproduced by permission of Felig—see text, current article.)

mid-third of the tibia. So called “shin splints” associated with the area of insertion of the origin of the tibialis anterior and other extensor muscles, may be more traumatic than usual, and due to a stress fracture of the tibia. The X-ray picture of this lesion a few weeks after the pain appears can be very worrisome—suggesting at times an osteogenic sarcoma. Leg amputations have been done as a result of such a mistaken diagnosis. Now that this benign lesion is more readily-identified, such a tragic sequence of therapy does not occur. Happily, the history and a follow-up X-ray clarify the etiology. Rest alone for a short period suffices as therapy.

Most distance runners now absorb the force of impact on the heel—and such is greater than one’s actual weight. It is for this reason that good running shoes have a thick-cushioned heel. Such may be enhanced by what are called orthotics. Each foot will strike the ground several hundred times per mile, the number obviously depending on length of stride. Incidentally, the English word “mile” is derived from the Latin “milia passuum,” meaning a thousand paces or strides. Runners of all long distances tend to land on the outside of the foot and roll medially; however, some distance runners now are becoming “toe runners”—taking the impact more on the front of the foot. This is considered by some the style of the future, providing a softer impact and enhancing a faster pace. As most marathons are run on macadam and cement surfaces, the value of this change in style is evident. With this technique, the foot-arches may suffer additional strain and it will be interesting in the future to determine whether the type of complaints by marathoners will alter.

Johnson, a US Olympic team coach, has described the foot-contact of the great marathoner Frank Shorter.⁸ According to studies, his foot-strike is directly beneath the center of mass and on the outside edge of the ball of the foot with a settling on the heel and rolling full range up and over the toes. Johnson emphasizes attention to “form” in running. He quotes one orthopedic surgeon that 35% of biomechanical injuries result from excessive mileage. Johnson thinks good form is protective.

Cardiac Aspects

The previous paper¹ ended with the question of whether running might be of health value. Pertinent to this is the question: Can atherosclerotic lesions decrease in size? We must keep in mind that the present large “first-generation” of joggers is composed of a high percentage of middleaged individuals who have started the activity quite late in life. For exercise to improve local circulation morphologically, one of two mechanisms must be involved—an increase in calibre of vessels or in number of vessels (or both, of course). The coronaries of DeMar (Mr. Marathon) were of unusually large calibre, and there was an insignificant amount of atherosclerosis.⁸ Bassler has concluded that marathon runners have less coronary atherosclerosis than anticipated.⁹ Blankenhorn¹⁰ has demonstrated that atherosclerotic lesions can be arrested or even diminished in individuals with Type Two and Type Four

lipoproteinemia. Mann et al¹¹ have assumed marathon running had a beneficial effect on coronary arteries. Rehabilitation of some patients who have had myocardial damage has consisted of running programs.¹² These types of observations and opinions and practices have given a sense of "health-security" to marathoners; however, a shocking tragedy in 1973 led to reassessments of risks in running.¹³ That year, the Boston Marathon was run under unusually-hot and humid conditions. A 44-year-old trained participant collapsed after 24 miles. He was resuscitated, but died 50 days later, with an extensive transmural anterior myocardial infarction. The coronary arteries, at autopsy, were free of significant atherosclerosis. It is well-documented that heat-stroke can cause extensive cardiovascular disease.¹⁴ In such cases at autopsy, myocardial damage is usually characterized by patchy necrosis and hemorrhage;¹⁴ however, the lesions may be much more extensive. Knochel¹⁵ has found electrocardiographic evidence of transmural infarction in soldiers with heat-stroke. Of historical interest is the notation that Pheidippides, the original and first-recorded runner of the marathon, fell dead after delivering his message. How much armor he was wearing and how recently he had run over 100 miles to Sparta is unknown.¹⁶

The point to be emphasized is that the "mystique" that marathon running is certain "protection" for the heart must be modified. Obviously, the heart can be damaged in a setting of heat and humidity even when coronary vessels are normal. Therefore, when running, think in terms of "training"—and not "straining." Furthermore, if one does not enjoy running, it will be done too infrequently for any potential benefit, which raises the question of how much running one must do to derive any assumed health effect.

Subsequently the "wall," and why 20 miles is called the "halfway mark" in a marathon race, will be discussed.

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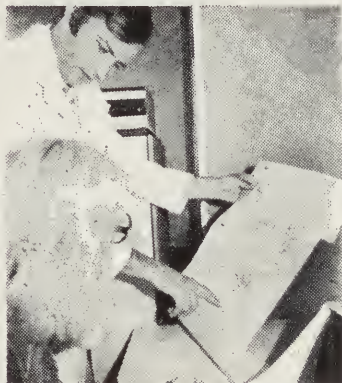
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Special Section on Running
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Athlete's Foot Due to Fungus Infection—Foot Rash is Fungus

By FRANK CHAPPELL

Mr. Chappell is Science News Editor of the American Medical Association, 535 N. Dearborn St., Chicago, IL 60610, where he can be contacted for reprint and other data.

The term "athlete's foot" was coined by an advertising man in the early 1930s to promote a patent remedy for fungus infections of the foot.

The popular term is a misnomer, says the AMA. You don't have to be an athlete to have a fungus infection of the foot. Anyone can have it.

Some people are more susceptible than others. A man may have the ailment for years and his wife will remain free of it. Doctors know that most of the efforts to prevent athlete's foot—chlorine footbaths at the swimming pool, disposable slippers, boiling of socks and treatment of shoes—are not helpful. Athlete's foot is almost never "picked up."

The most common form of athlete's foot is that which causes redness, cracks in the skin and itching and burning of the feet, particularly between the toes. The same fungus can cause blister eruptions of the soles of the feet.

Prevention requires that the skin of the feet, especially between the toes, be kept cool and dry. When successfully done, this is more effective than the use of medicated powders, lotions, creams or ointments. Relief may be obtained by simple and bland substances, but a specific approach to treatment will often require the attention of a specialist with laboratory facilities for confirmation. Treatment should be aimed at the type of fungus causing the infection.

Warm, moist skin encourages the growth of all types of fungi. It is difficult to eliminate the fungi entirely, but their effects can be kept under control by keeping the feet cool and dry. □

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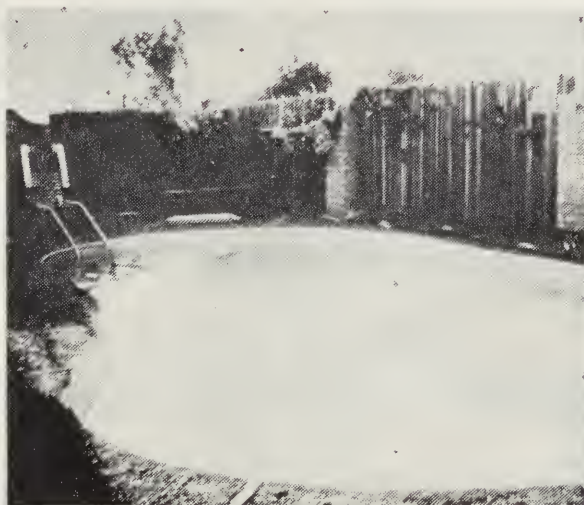
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By KENNARD L. YAFFE, MD

Dr. Yaffe was Chairman of the Faculty's Committee on Drugs. He can be reached for reprints and other data at 1211 Cathedral St., Balto., MD 21201.

There continues to be increasing concern among the profession and the general population about the apparent widespread abuse of psychotropic drugs. A recent bulletin from the FDA regarding suicide by Propoxyphene (Darvon) estimates 1,000-2,000 deaths yearly—some related to taking other drugs and/or alcohol at the same time, with or without understanding the danger.

This drug, when taken over an extended period of time, can produce physical and psychological dependence of the morphine type and this may occur in doses not much larger than therapeutic doses.

Because of the concern about this drug, the Committee on Drugs of the Medical and Chirurgical Faculty urges physicians to consider before prescribing Propoxyphene, the following:

1. Is the patient suicidal, prone

to abuse or addiction?

2. Possible dangerous effects if taken along with alcohol, tranquilizers or sedatives.
3. Can a drug with less dangerous potential be substituted?

In addition, I cannot emphasize strongly enough the need for physicians to be aware of the role they may play in inducing addiction. Enormous amounts of psychotropic drugs are being prescribed, too often for trivial problems, in too large quantities and for too long a period of time. It is necessary for us to be cautious each time we prescribe psychotropic drugs—to consider if the drug is necessary—is this problem simply a vicissitude of life that needs to be lived through? If the drug is really necessary, consider the amount prescribed; consider how long it should be maintained and use it for the shortest appropriate time.

We, as physicians, must not take the easiest way unless it is in the best interest of our patient; to do otherwise is to go against the first principle in medicine, "First, Do No Harm."

Medical Miscellany

Children Sought for Insect Sting Allergy Study

Johns Hopkins allergists at Good Samaritan Hospital in Baltimore are seeking youngsters between the ages of 3-16 who have had a rash or generalized itching after an insect sting to participate in an allergy study. The doctors hope to learn how to predict the likelihood of such children's suffering with similar or more serious reactions if stung again.

Participants in the study will receive a free evaluation of their sting sensitivity and advice concerning necessary precautions to take if found allergic. Free treatment with an effective new therapy will be offered to certain participants, along with follow-up examinations and consultations with all participants' physicians.

Interested individuals should call the Allergic Disease Center at (301) 323-2200, ex. 394.



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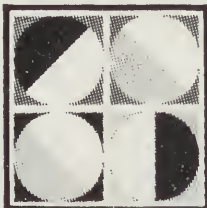
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Certificate of Need: A Physician Concern

By ALBERT M. ANTLITZ, MD and EDWARD BOYER

Dr. Antlitz is Head of the Division of Cardiology at Baltimore's Mercy Hospital, and is a Member of the Executive Committee of the Central Maryland Health Systems Agency. Mr. Boyer is Vice President of Corporate Planning and Program Development of the Maryland Health Care System, Inc. and Former Acting Executive Director of the Central Maryland Health Systems Agency. For reprint and other data, write Dr. Antlitz at 301 St. Paul Pl., Balto., MD 21202.

Introduction

Certificate of Need (CON) refers to a program wherein a license to open a newly-created hospital or related institution or a license to continue those which have relocated, modified or changed its services is issued.¹ The CON and license may only be granted if the hospital or related institution conforms to or is not inconsistent with the comprehensive health plan for the region. The Maryland State Health Planning and Development Agency (SHPDA) makes the final decision regarding conformance to the health plan and issues the license after considering recommendations of the appropriate Health Systems Agency (HSA).

Organizations subject to CON regulation are hospitals, related institutions (nursing homes, residential treatment centers, home health agencies, etc.), kidney disease treatment centers (including freestanding hemodialysis units), ambulatory surgical facilities, health maintenance organizations and other health services or programs specified as requiring a CON under State or Federal law.

The primary purpose of the CON program is to regulate major capital expenditures and changes in health care facilities with the intent of controlling costs. At the same time, issues such as availability, accessibility and continuity of health services are addressed.

Currently, physicians practicing in a private office setting in Maryland are not covered by Federal or State CON regulations. The necessity for physicians to be aware of and understand the CON process

remains of vital importance, as there is constant pressure both at State and Federal levels to include the private practice of medicine in the CON program. This knowledge is necessary for appropriate reaction to these attempts, as one cannot adequately deal with that which is not understood. The more complete the perception, the more accurate and intelligent the response.

Many, if not most, physicians practice in a hospital or health institution included in the CON process and thus are directly affected. The CON program is related to any improvement, updating or modification of services, from X-rays to surgical suites, air conditioning to number of beds. Any modification of services or capital expenditure must be approved and licensed by the State agency. The physician cannot be passive or uninformed about such vital issues affecting the quality and scope of care available to patients. The physicians must be part of the decision-making process and to be so, must be informed and knowledgeable.

CON legislation was first enacted in Maryland in 1968² and amended in 1978³ to incorporate the new Federal regulations resulting from the passage of Public Law 93-641.⁴

At that time, the CON process became a requirement for each SHPDA to administer. Each state was required to enact CON legislation and regulations by 1980 or risk the loss of Federal funds for health care programs. Revised regulations governing the State CON program were issued on March 24, 1978.⁵

Criteria within the minimum requirements as stated in the Federal legislation were established by which an applicant is reviewed. The more salient of these criteria are: 1) The relationship of the project to the health systems plan adopted for the region; 2) The need for the proposed services or facilities by the population served

or to be served; 3) The availability of less costly or more effective alternative methods of providing such services and 4) The immediate and long-term financial feasibility of the proposal and the impact of the proposal on the costs of, and the charges for, the provision of services by the applicant and other institutional health services providers in the area. In addition to the 12 review criteria, there are criteria concerning proposed new institutional health services for inpatients, and also special criteria with respect to Health Maintenance Organizations.⁶

The Certificate of Need Process

The process an applicant must follow to obtain a CON varies from state to state and can also vary within the HSAs of a single state. For example, Maryland has five HSAs with different CON processes. The authors have chosen to present the process used by the Central Maryland Health Systems Agency (CMHSA).

The CMHSA includes Anne Arundel, Baltimore, Carroll, Harford and Howard Counties and Baltimore City. It is a region of high-density population containing approximately 2,200,000 people, roughly one-half of the state's total population. The Central Maryland health service area contains more than 50% of the state's health care resources.

The CMHSA is a private, non-profit corporation with a board of community volunteers called the Governing Body. This has 101 members, 55% of whom are consumers (senior citizens, homemakers, business people, etc.) and 45% providers (physicians, dentists, nurses, hospital administrators, etc.). Local elected officials are also members. A 25-member Executive Committee is elected by the Governing Body. The CMHSA also has, as part of its structure, six local health planning councils known as Subarea Advisory Coun-

cils (SACs), one for each of the six jurisdictions. The SACs provide input and make recommendations on such issues as plan development and CON applications which relate to the particular jurisdiction. Impact on the CON program may be made at each of these levels.

The primary steps an applicant must take to process a CON application through the CMHSA and the SHPDA are as follows:

1. Submission of Letter of Intent: The applicant must submit contemporaneously to the Health Facilities Coordination Office (HFCO) of the Maryland Department of Health and Mental Hygiene and the CMHSA a letter of intent at least 60 days prior to the submission of a formal application. The letter of intent notifies the reviewing agencies that a capital project or change in service is being contemplated by a prospective applicant. The letter of intent should include such information as project purpose, brief description of the program, estimated costs, timetable, etc. When the CMHSA receives a copy of this letter, contact is normally made with the applicant to begin discussions and provide technical assistance if necessary.

2. Registration of Formal Application: Once the 60-day letter of intent period has expired, the applicant may then submit a formal application to the HFCO. The HFCO logs in the application and forwards it to the CMHSA for a pre-registration review. The CMHSA has 15 days to review the application for completeness and then recommends to HFCO whether the application should be registered. Assuming a positive review, the HFCO assigns a registration number to the application and the formal review process begins. From the date of registration, the CMHSA has 90 days to review the project and forward a recommendation to the SHPDA.

3. Process: Once registered, an application is reviewed and analyzed by the CMHSA Certification and Review staff, which then prepare a report and make recommendations regarding the proposed project. This preliminary staff re-

port, along with the application, is distributed for review and comment to the SAC affected by the applicant's proposal. For example, a proposed project by a hospital in Baltimore County would go to the Baltimore County SAC for review and comment.

The final staff report, with SAC review and comment and the application, is then forwarded to the Certification and Review Committee of the CMHSA, which conducts further studies and hearings and makes recommendations for the CMHSA Executive Committee's consideration. The Executive Committee reviews the application and associated data, may conduct appropriate interviews and then makes a final recommendation which is forwarded to the SHPDA.

During the 90-day review period, the applicant has an ongoing relationship with the CMHSA staff as well as attending and interacting with the various committees; i.e., Subarea Advisory Council, Certification and Review Committee and Executive Committee. This continued interaction between the applicant and the CMHSA staff cannot be underestimated. Staff must have a clear understanding of the applicant's proposal as well as the underlying assumptions being used if a knowledgeable and proper staff report is to result. A cooperative rather than an adversarial environment should be developed. It is usually beneficial for the applicant to discuss the proposal with staff as early in the process as possible—preferably at the time a letter of intent is being developed. This practice will normally lead to early resolution of potential problems occurring during the course of the review process. It should be noted that CMHSA staff should not be expected to provide, during these preliminary meetings, an absolute judgment as to whether it will recommend approval or disapproval for the project. The value of the meetings is to identify potential problem areas, provide assistance or direction where necessary and to begin meaningful dialogue so that future misunderstandings can be avoided. As noted, final CMHSA action is taken by the Executive

Committee. This action is based on the recommendations developed by the CMHSA staff report, the SAC and the Certification and Review Committee, along with the information provided in the application and any additional verbal or written statements made by the applicant or other interested parties.

4. Recommendations of the CMHSA: CMHSA actions with respect to applications for Maryland CON are limited to one of the four following recommendations: 1) approval, 2) disapproval, 3) approval with specific conditions and 4) action deferred for a specific time not to exceed 90 days, with explanation. The recommendation is then forwarded to the SHPDA for final action. The SHPDA will then normally act on the CMHSA recommendation within a 30-45-day time period. In case of deferral of action by the State agency, the maximum limit placed on the total review process is 210 days from the date of registration.

How Physicians Can Impact the Process

The CON program is quite technical—relationship to the health plan, statistics of various forms and assessments of needs must be considered. The process is, however, also political in nature.

Besides gathering technical data and supporting evidence, community support is also vital for a successful application. Elected officials, concerned community groups and related institutions, medical groups and health facilities must all be approached and informed. Their support must be actively sought and evidenced to the SAC, CRC and Executive Committee and, if necessary, to the State Agency.

The CON program should also be approached on a more basic level. The approval of an application is based to a great extent on the health plan of the region. To properly impact this, physicians must be involved with the entire health planning process. This means membership and participation in the HSA and SAC. Reading, analysis and reacting to the Annual Health Plan of the local HSA and that of the State Agency by

physicians and the Medical Societies is mandatory.

The point to be made is that physician involvement cannot begin and stop with the CON program. If impact is to be felt, physicians must participate in the entire health planning process.

References

1. PL 93-641, Title XV of the Public Health Service Act, Section 1523 (a) (4) (B).
2. Art. 43, Sec. 556, 559, Annotated Code of MD; Art. 41, Sec. 59c, Annotated Code of MD.
3. Art. 41, Sec. 59 and Art. 43, Sec. 559(a-i), Annotated Code of MD.
4. Title 42, CFR, Part 123, Subpart E,

Secs. 123.401-123.411 (Effective Feb. 22, 1977).

5. COMAR 10.24.01, Determination of

Certification of Need for Health Care Facilities.

6. Ibid., Sec. 10.24.06 (B) (2) (a-1). ☐

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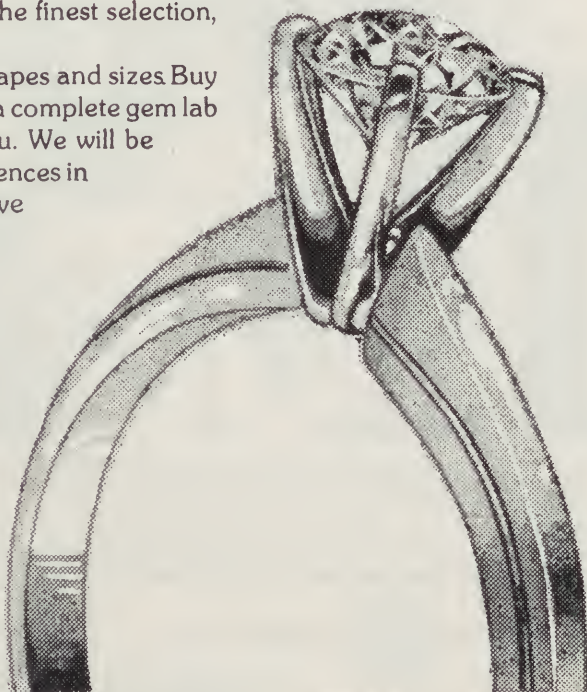
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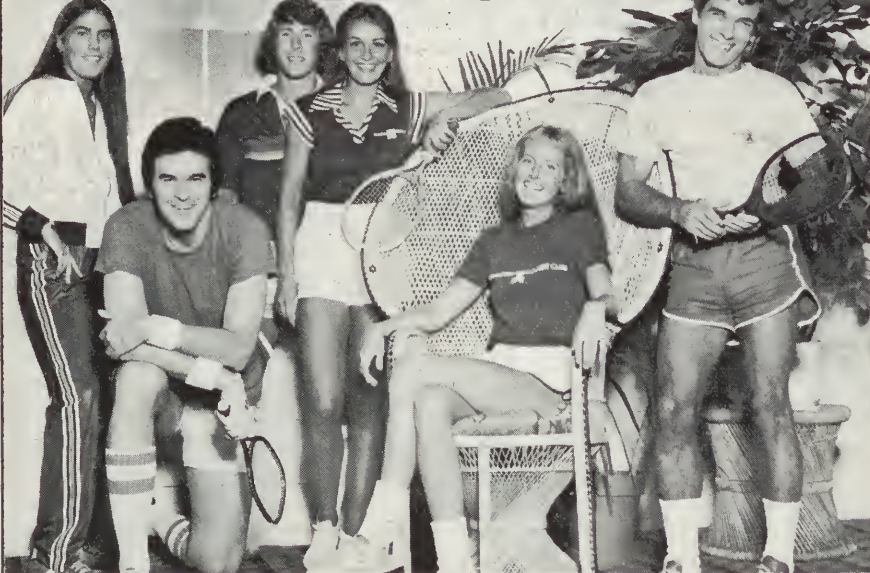
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Medical Miscellany

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It's the American Physician's Art Association, an organization now in its 42nd year. This year it will meet with the Southern Medical Association and present its annual exhibit. The APAA has nearly 500 members across the country.

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All physicians who work in the fields of painting, sculpture, photography, graphic arts, design and creative crafts are encouraged to join the APAA to submit entries for the November exhibit.

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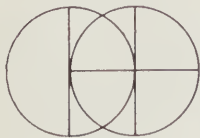


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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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*This drug has been classified “probably” effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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For use in the treatment of infant colic (syndrome).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cyclopia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

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The Physician as a Debtor

By JOHN C. KRANTZ, JR., PhD

For reprint and other data, write Dr. Krantz at Gibson Island, MD 21056.

The Apostle Paul, in his letter to the church at Rome, declared "I am a debtor both to the Greeks and to the Barbarians; both to the wise and the unwise . . ." He was determined to make available to the entire world the beauty and satisfaction of the Christian faith. In a similar manner, the physician is debtor to a host of men from many walks of life who have provided him with the tools of healing. From this chosen group he has inherited the skills which provide him with the emotional satisfaction of serving one's fellow man. In this sense, like St. Paul, the physician is a debtor.

Oliver Wendell Holmes took delight in parading before his medical colleagues the debt what medicine owes to the lay empiricists. He wrote "Medicine learned from a monk how to use antimony, from a Jesuit how to cure agues, from a friar how to cut a stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmaster how to sound the eustachian tube, from a dairy maid how to prevent smallpox and from an old market woman how to catch the itch insect."

One is constrained to continue the ever-increasing list of those in other walks of life who have made definitive contributions to medicine. When the Spanish invaded Peru in 1531, Francisco Pizarro learned from the Incas that Cinchona bark infusions would cure malaria. He took the bark to Europe, where it enjoyed widespread use in the treatment of malaria. In 1820, the two pharmacists Pelletier and Caventou isolated the alkaloid quinine from the bark. Just prior to that date, the youthful apothecary Frederick Wilhelm Adam Surtturner isolated morphine from opium. The chemist to the French wine industry, Louis Pasteur, laid the foundation stones for medical bacteriology. In the early years of the 20th Century, Madame Curie,

the distinguished physicist, worked with tons of pitch blind to obtain milligram quantities of radium. I was Stephen Hales, an English clergyman, who measured the blood pressure of a horse in 1733 by inserting a nine-foot tube into an artery and observed the powerful pressure of the blood. It was a dentist, William T. G. Morton, who introduced anesthesia into medicine in 1846. The soil chemist, Selman Waksman, isolated Streptomycin from soil in 1941, and it was found to be useful in the treatment of tuberculosis. Added to this list should be another clergyman, the Reverend Edward Stone of England, who in 1763 observed the medicinal value of willow bark. The bark yielded salicin, and aspirin followed at the turn of the century. This medicine is consumed in quantities of 20-30 tons daily in safety by the American public mainly for the relief of pain. There is likely no other substance that has provided relief for as many people as has aspirin.

When the physician walks into the sick room of his patient, looking down on him from the great Valhalla of Medicine are the great medical giants: Koch, Osler, and others—he is their representative—but he is also a debtor to that great galaxy of laymen of the past who have made many valuable contributions to the profession. □

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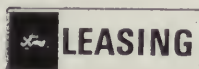
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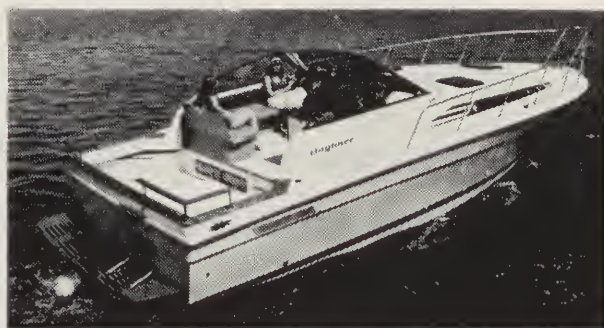
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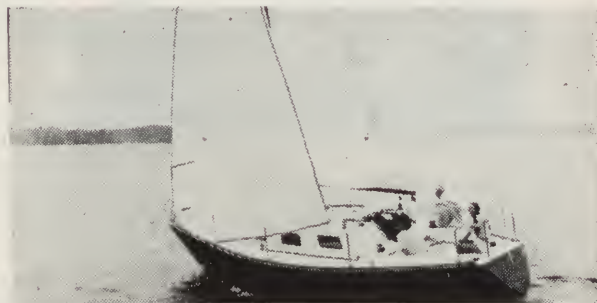
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The Strange Case of Dr. Pierpont—Could This Happen to You?

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***Part 1: The Spoiler:**

A Biographical Sketch of Ross Zimmermann Pierpont, MD—

by Blaine Taylor . . . p. 58

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***Part 2: The Buscemi Case and Its Ramifications (Selected Excerpts From the Unpublished Book Manuscript of All the Supreme Court's Men)**

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***Part 3: A Physician's Political Life: An Exclusive Interview with Dr. Pierpont—**

by Blaine Taylor . . . p. 73

EDITORIAL: Dr. Pierpont's Case and "Educational Malpractice"

Whether one agrees with Dr. Pierpont's politics or not is not important. His story is. Dr. Pierpont alleges that over 100 Maryland physicians were introduced to the Baltimore Grand Jury probe in one way or another during a two-year period. The fact that the number selected out for indictment was only 10 is not comforting. Nor is the fact that only **one** actually went to trial. Fortunately, that one, Dr. Pierpont, had the courage to tell his side of the story in order that others will not fall prey to similar legal hassles, onerous financial plight and unending mental anguish.

If only one other Maryland physician is spared the anguish that Dr. Pierpont has experienced as a result of reading his story, then this Editor will be satisfied that the publication of his manuscript was worth the effort. I believe that Dr. Pierpont feels the same.

Unfortunately, we all too often repeat our errors and fail to learn from history. Dr. Pierpont's case will be forgotten and this issue of the **Journal** will be found from time to time in the archives of a few libraries. The medical schools of Maryland can, however, better prepare future physicians for the practice of medicine in this state as well as elsewhere. We do not practice our specialties in a legal vacuum. Regardless of medical or surgical interest, we daily face scores of State and Federal laws that regulate our practice. To be ignorant of the law is no excuse. To have received little or no introduction to the laws affecting the practice of medicine, in medical school, is evidence of "educational malpractice."



Note: The opinions and assertions expressed throughout this three-part section are entirely those of Dr. Pierpont. Publication does not imply endorsement by the **Journal**, the Medical and Chirurgical Faculty of Maryland or any other organization with which Dr. Pierpont is associated. ☐

Part 1: The Spoiler:

A Biographical Sketch of Ross Zimmermann Pierpont, MD

By BLAINE TAYLOR

Contact Mr. Taylor, *Journal* Managing Editor, for reprint and other information c/o the *Journal*, 1211 Cathedral St., Balto., MD 21201.

Introduction

Dr. Ross Z. Pierpont stood before an assemblage of reporters and banks of television cameras in Annapolis on July 1, 1974, after he formally filed as a candidate in the Republican Primary Election for the United States Senate seat held then (as now) by Charles McC. "Mac" Mathias, Jr.

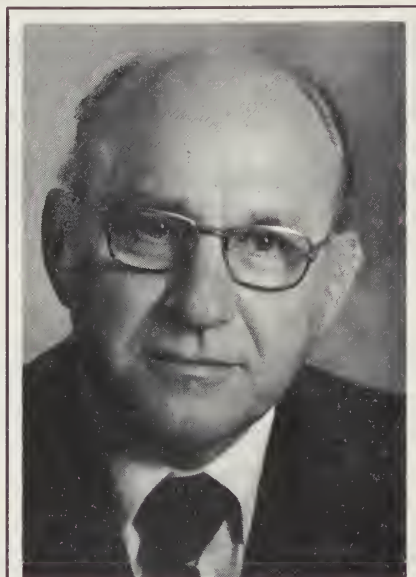
Dr. Pierpont stated: "I am innocent of any wrongdoing, and I am the victim of a witchhunt and an attempted political assassination."

Hanging ominously over Dr. Pierpont's head were charges of illegal drug prescriptions that carried with them a fine of \$100,000 and two years' confinement in prison. Eventually, Dr. Pierpont would have his day in court and be adjudged not guilty of all charges, but not before long months of mental anguish to himself and his family and a personal cost of \$50,000 in legal fees.

The following three articles—one by him—attempt to tell his story, if that can adequately be done.

A Churchillian Figure

Dr. Pierpont, 61, has been Chief of Surgery at Baltimore's Maryland General Hospital since 1960. A non-smoker, he arises at 4 AM and



DR. PIERPONT
(Photo by Udel, Baltimore.)

generally lives up to his reputation as characterized once in the Baltimore Sun: "Flamboyant and energetic."

A tough-talking, rough-hewn,

"rugged individualist" of the old school of American pop heroes ala John Wayne, the blunt, balding, bespectacled doctor resembles somewhat the bulldog-like late former British Prime Minister Sir Winston Churchill, whose statue and glass muglike-images grace the den of his Homeland residence in suburban northeast Baltimore, along with flags of the US and Maryland and shelves of books on history and politics.

Politics. That's the word—not medicine—that comes to mind when one conjures up the fighting image of Ross Pierpont. In a whirlwind career spanning the last 12 years of Free State history (see Table 1), he's run (always unsuccessfully) for every office from the US Senate (twice) to Governor of Maryland (twice) to Mayor of Baltimore (once) to Congress (once).

Always an independent-minded person, he switched political parties in 1970 and kept right on running. Will he ever stop? Even he doesn't know, as the following exclusive *Journal* interview bears witness.

Some view him as a racist reactionary and, perhaps, a fool, but he is neither, as his political track record and medical career—when examined closely—will show.

Concerning the first, 1964 was the year that saw the advent of segregationist George Wallace as a Presidential candidate in Maryland, but two years later, Ross Pierpont became the first white man in the state's history to choose a black running mate. He did so twice again, in 1971 and 1978 (on the latter occasion, he asked Annapolis physician and Med-Chi member Aris T. Allen to run with him; Allen ran with J. Glenn Beall instead.)

Educationally, he received his

Table 1: The Pierpont Candidacies, 1966-78

Year	Office Sought	Party Affiliation	Main Candidate Opposed
1966	Governor	Democrat	Carlton Sickles
1968	US Senator	Democrat	Sen. Daniel B. Brewster
1970	US Senator	Democrat (but never filed)	Sen. Joseph D. Tydings
1970	US Congressman	GOP	*Rep. Clarence D. Long
1971	Mayor of Baltimore	GOP	Baltimore City Council President William Donald Schaefer
1974	US Senator	GOP	Sen. Charles McC. Mathias, Jr.
1978	Governor	GOP	J. Glenn Beall, Jr.
1979	?	?	?
1980	?	?	?

(*NOTE: Dr. Pierpont became a Republican in 1970; he has lost all of the above seven electoral contests.—BT.)

MD from the University of Maryland School of Medicine and his BS from the U of M's School of Pharmacy. A surgeon in private practice with offices in Towson and Havre de Grace, he is on the staff of five major metropolitan Baltimore-area hospitals and is a member, fellow or diplomate of numerous professional societies as well, including Med-Chi.

A golfer, squash and racquetball

player, Dr. Pierpont is also an investor in real estate, oil and gas wells and serves on several public advisory boards and committees, too.

Born at Woodlawn, MD on Sept. 7, 1917, he started out "broke," he says, but is now reputed to be a millionaire. In 1974, his daughter Christine Celeste (now 27) married Baron Lippold von Klencke of Hanover, sole heir to

Haemelschenburg Castle in Germany.

The Pierponts (he married the former Grace Schmidt in 1942) have a private staff of two who have been with their family for more than 25 years: housekeeper Elaine Cole and chauffeur Charles Shipley.

The story of what happened to Dr. Pierpont in 1974—told in his own words—follows. □

Part 2: The Buscemi Case and Its Ramifications

(Selected Excerpts From the Unpublished Book Manuscript of *All the Supreme Court's Men*)

By ROSS Z. PIERPONT, MD

(Edited by Blaine Taylor)

For reprint and other data, contact Dr. Pierpont at 5602 Enderly Rd., Balto., MD 21212.

Enter Buscemi

It turned into a long day and night as I retraced my way through the nightmare . . .

While in my office in Havre de Grace on March 22, 1974 in the morning and during the course of patient flow, my nurse brought a man into my consulting room. The man was a stranger to me. The nurse gave me the patient's record card showing a complaint of severe pain in both legs. She left the room.

The patient, now known to me as Salvatore Buscemi, began to talk in great excitement that quickly approached hysteria. Hand and body gestures indicated some loss of self-control. It became clear that I was dealing with either a potentially-violent (mentally-disturbed) patient or a drug addict badly in need of "a fix."

As I was examining the patient's eyes, arms and legs, he confessed he was an addict. He said he had come to my office in desperation. He reached into his pocket and pulled out a railroad ticket to Kentucky. He said he was on his way to the drug treatment center in Kentucky, but he couldn't make it there without drugs to see him through. He said he was going to do something desperate if he didn't get help at once.

As the patient spoke, his agitation increased. He stated he had been a numbers runner on "the Block" (a location of bars and striptease clubs in downtown Baltimore—ed. note) and had met me during my prior political campaigns. He stated he was in with the Block gang, and added threats more or less in these words: "You're a good guy, Doc. Please don't make me do anything wrong. I'm desperate. Don't make me do what I don't want to do," he kept repeating. During such talk, the man put his hand into his pocket and pointed something

at me. Whether he carried a weapon or not, I do not know. He never pulled a gun on me, but the pointing was sufficient.

I told the patient I did not treat addicts and would not do so now. I would, however, refer him to a treatment center, specifically Man Alive at Johns Hopkins Hospital in Baltimore.

As I told Buscemi I would not treat him for addiction, he became so agitated I began to think of ways to protect myself. Normally, addicts are not prone to physical assault, but in his state and possibly thinking of drugs normally found in a clinic such as the one in Havre de Grace, an addict denied drugs could go to almost any lengths to get them.

I tried to calm Buscemi, but he refused to quiet down. Again he showed me his railroad ticket. He pleaded with great sincerity for me to help him get to Kentucky where he was going to turn himself in.

I decided not to run the risk of violence either to myself, another innocent person or my family. He asked for 200 tablets of Dilaudid. I reasoned with him that his request was out of line with the need, and finally wrote him a prescription for 80 tablets of Dilaudid. I entered the prescription on the patient's record, and he paid my usual fee of \$15 (in cash). I gave the \$15 and the record card to my nurse. After Buscemi had left, I considered calling the Harford County Police, but decided against it and went about my work.

Buscemi returned to my waiting room Monday morning, March 25th, where he appeared disturbed—unable to sit or even stand as a normal patient does. I have never refused to see anyone with or without an appointment (a rule known to my nurse) and she finally brought Buscemi into my consulting room.

Buscemi cried. He said he had been in an auto accident in which he had lost all his clothes, the prescription with them. He babbled about violence which he had

either done to others himself or seen done to others; I am not sure which.

Anger got the better of me and I pushed Buscemi out of the office physically. Shaken, but regaining my control, I went back to my office, and Buscemi almost immediately pushed his way in again, this time to say I was killing him if I sent him away with no help. He would never make it back to Baltimore alive, he said. His condition seemed to be deteriorating so badly that while I refused him any Dilaudid, which he begged for, I prescribed a mild sedation, Demerol (24 tablets, 50 mg. each).

Buscemi went away only to come back once again, perhaps an hour later, to see me. I thought of calling the Harford County Police, but decided the risk was not worth it; I have handled hysterical and somewhat violent cases before. By now I was also convinced he was a most unusual addict, quite possibly with the connections on the Block he had bragged about. Buscemi had his hand in his pocket, and at this point he pulled out a piece of paper I recognized as a badly mutilated prescription blank of the Clinic. The blank proved, he said, that he had been in an accident and had never "cashed" his prescription from me. Further, he was an undercover agent, though an addict, of the Baltimore City Police Department. While talking, he pulled out a ticket to somewhere in Texas, I cannot recall where, but it was supposedly to another Federal drug treatment center replacing Lexington, KY, which had been closed. Buscemi said I could easily find out that he was telling the truth by calling the Baltimore Police and asking for Lt. Leon Tomlin of the Narcotics Squad. He gave me Tomlin's number. I admit I felt relief, and the strangeness of a Baltimore City Police agent, and addict, traveling to seek me out on two separate occasions in Havre de Grace, passed me by.

I immediately called the number Bus-

Buscemi gave me and spoke with Lt. Tomlin. I asked him about Buscemi and was assured by Tomlin that Buscemi was in fact helpful in their work. While I was on the phone with Lt. Tomlin, Buscemi broke in to tell me I should ask Lt. Tomlin about his getting drugs at Richmond's Drug Store (in Baltimore as it turned out). Buscemi said Richmond's Drug Store knew him as an addict working with the Police and entitled to drugs. I relayed this question to Lt. Tomlin, whose answer was something like "Uh-huh." Looking back in the light of later developments, I can see that Tomlin had not really given me a full verification of Buscemi's status. However, the addict was standing by my telephone and talking to me as I spoke with the Police Lieutenant, and if Lt. Tomlin did not approve of Buscemi's actions, he had only to say the word. The opposite was true. I was led, by the circumstances and the conversation, to believe I was dealing with a legitimate Police Department operation using an addict as an undercover agent.

I telephoned Richmond's Pharmacy. The pharmacist confirmed knowing Buscemi as an addict, as Buscemi said. If I wrote him a prescription, they said, and identified Buscemi as an addict on it, they would fill it on a one-time basis. I thereupon wrote Buscemi a prescription which was to replace his Friday prescription; However, I reduced the quantity to 40 tablets and identified Buscemi as an addict on the blank, as the pharmacist directed. The prescription was entered on the patient card and returned to my nurse. The usual charge of \$10 for a second visit was also entered. This charge was later billed by mail, including a "Past Due" notice, but it has never been paid.

On Tuesday, March 26th, Buscemi came into my waiting room in Baltimore and waited to see me. Something now began to arouse my suspicions—the pursuit was too constant to be normal. I refused further assistance of any type. I ordered him out of the office. His Baltimore record contains this notation dated March 26, 1974, initialed by me: "This man is a drug addict. We will not give him any Rx."

During the next few days, Buscemi appeared in my Baltimore office on additional occasions, and each time we refused to have anything to do with him.

When I walked into my Baltimore office Friday afternoon, on March 29th, Buscemi was seated in the consultation room. He asked for a prescription for drugs. I refused in some anger and ordered him out. He told me he had brought Lt. Tomlin of the Baltimore Police with him to prove he was an addict working with the police as he had said all along. I looked to see what he was talking about, and saw a man in the hall. He showed me his Police ID card which identified him as Lt. Tomlin, the same man I had spoken with from Havre de Grace on Monday.

The presence of Tomlin brought me

to a full showdown. Whatever these men were up to, the Police were clearly part of it. I had had my fill of Buscemi, and at this point I had no more confidence in Tomlin than I had in the addict. I demanded of Tomlin in a loud voice heard throughout my office: "Are you trying to trap me? Is this a set-up?" Tomlin did not answer. In language beyond repeating I told both men to get out of my office and stay out. Buscemi continued to press for drugs, but Tomlin then said something like "Come on Sal. We might as well get out of here." They left. I had not realized a female patient was waiting for me in an adjacent examination room, and I apologized to her for the language she had been subjected to.

On Saturday, March 30, 1974 in the early afternoon, Buscemi rang the bell at my home in Baltimore. He said he had brought me a color television set. He would not go away. Cajoling, threatening, pleading and offering goods, money—anything I would ask for would be mine in return for a prescription. My wife was totally unprepared for the scene and was terrified—almost in shock. Finally, Buscemi left the box he had brought. It was in my home until Monday, Apr. 1, 1974, when Buscemi came with a man he said was his brother and took the box away. I never saw the contents of the box.

On Friday, May 31, 1974, Lt. Tomlin handed me a subpoena to appear before the Baltimore Grand Jury on the next Tuesday (June 4th). I immediately called the Baltimore State's Attorney's Office, in Tomlin's presence. As I put through the call, Lt. Tomlin became agitated and did not want to stay. While holding Tomlin by the arm, I spoke with a Mr. Bollinger of the Baltimore State's Attorney's Office. I told him this looked "Fishy as hell to me. It looks like a trap and a set-up." He made no comment that I recall. I offered to testify before the Grand Jury, but the requested date on June 4th was impossible on such short notice due to a complete operative schedule that day. He said he would postpone my appearance one week, to June 11th. Following this, Lt. Tomlin brought a summons to my home for June 11th. One day prior to the scheduled appearance, a Mr. Cremin of the Baltimore State's Attorney's Office called me in Havre de Grace to advise I would be required to sign a waiver of immunity. He advised obtaining legal counsel. To this point, I had never even mentally doubted my position—in fact, I had almost forgotten "the week of Salvatore Buscemi."

Now, however, a new type of threat was taking shape. That night, I spoke with my attorneys, Edward Johnston and Nevitt Steele, by telephone, and they advised me not to sign anything, including the waiver of immunity required before appearing before the Baltimore Grand Jury. I had attempted to get attorney George Russell, but he was in White Sulphur Springs, WV attending the 4th Circuit Judicial Conference. He returned June 30, 1974, when I retained him.

They advised me not to sign anything.

Since the rest of the story was known to Nevitt Steele and they were in communication, it did not seem necessary to relate the progress of the events of June . . .

The Parren Mitchell/ Milton Allen Link

George Russell and I were conferring daily. He was having increasing difficulty with Milton Allen and couldn't understand why. I thought I knew why.

(Ed. Note: Mr. Allen was then Baltimore State's Attorney. It was his office that was prosecuting Dr. Pierpont's case. Dr. Pierpont's strong suspicion was that Baltimore Congressman Parren J. Mitchell was behind Allen in a political attempt to smear Dr. Pierpont and thus remove him as a threat to Sen. Mathias' reelection bid in 1974.)

The Olesker "Betrayal" . . . and Indictment

I had just drifted off to sleep when the phone rang. It rang several times before I realized just what was happening.

Fumbling with the receiver I said, "Hello."

"Is this Ross Pierpont?"

"Yes."

"This is Mike Olesker, Baltimore News American. I'm calling you to verify a story we've picked up."

"What's that?" I asked.

"We have it on good authority that your name is among those who are going to be indicted on drug charges by the Baltimore City Grand Jury. Since I know you so well, I didn't want to print anything except the facts about such a problem."

I was cornered. Dead-tired, but thinking straight, I reasoned that this reporter obviously had all the facts. He was continuing about dilaudid and Buscemi and facts surrounding the case which no one could possibly have known except the Grand Jury, the State's Attorney's office, my lawyers and myself.

My first inclination was to respond with "no comment." However, there had been so many responses of "no comment" by persons later proven to be guilty that this almost seemed an admission of guilt. My thoughts went on.

This Michael Olesker had been quite fair in the 1971 Baltimore City Mayoral campaign when he had spent a whole day campaigning with me. His in-depth article which followed was more favorable than most of the liberal press and I had been grateful. I was especially impressed with his fairness because he was the prototype of the liberal, far-out news hound: always probing for the soft underbelly, to report possible prejudice or bigotry. Only his quarry was suspect. Only the candidate could be all bad. This, unfortunately, is not uncommon today, as the mass media is a constant, malignant adversary.

At any rate, Olesker had been kinder and fairer than most, and I rather liked

him. More to the point, we had had several confidences over the years and he had never breached them. Nonetheless, Olesker had a deep, abiding distrust of me, all the same, just because I was a conservative but, we had shared a mutual respect . . . or so I thought.

I said "Look. If you will treat this off the record and confidential, I will tell you what I know." This to me meant he would not print.

"Absolutely," he responded.

"We are faced with a runaway Grand Jury, an entrapment and an illegal indictment, all of which we expect to dissipate with no problem."

"How?"

"My attorney, George Russell, is working with the damned foolishness and it is in a ticklish phase. We know it's nonsense and you have known me long enough to evaluate this ridiculous charge."

"Yes. Anything else?"

"I guess that's about all there is to it."

"Will you still run?"

"Absolutely."

We hung up. I went off to sleep, content that I had finished an off-record conversation with a trusted newspaper reporter. I was confident he would not breach Grand Jury secrecy by publication.

On Friday, June 28th, in the early afternoon, I was greeted with a screaming four-inch newspaper headline: **PIERPONT INDICTED**. The radio reports and all media were full of the story. All details were spelled out in a full front page exposé in the *Baltimore News American* under the byline of Michael Olesker, my confidante.

I immediately went incommunicado as well as one can with a surgical practice to look after and sick patients to see. The few people I saw, friends, colleagues and adversaries were instantly aware of the facts and I was deluged with sympathy, disdain, avoidance and snide remarks, literally the gamut of all human emotions during that one and one-half hours. I finally looked away from my patients and the hospital and got to George Russell's office.

There was no withstanding the fact that we were face-to-face with a catastrophe of major proportions. What had been a possibility or probability was now a fact, brazenly staring out of translucent news boxes all across the state. If anyone missed it, he was delivered the material as the lead story on the first radio or television newscast he heard . . .

A Death Threat, Campaigning Under a Cloud and the Indictment Thrown Out

Grace and I were jolted awake by a loud knocking on the front door and the doorbell ringing.

Bolting up in bed, I rasped, "What in hell is that now?"

Grace spoke quickly. "Be careful."

I got up and looked out the window. I couldn't believe it. The streets were crawling with police. Blinker lights were flashing up and down the block in front of the house. Police were on the lawn. I looked out to the lawn which goes around and behind the house and it was full of other police cars with lights flashing and police were everywhere.

"For God's sake, what have I done now?" I exclaimed. "The neighbors will think I'm a hardened criminal. Just what in hell is all this?" All the while, the pounding continued on the front door. I picked up an old shotgun, not sure what I was going to do and went downstairs.

"Who is it?"

"Dr. Pierpont, this is the police. We need to talk to you."

"I don't give a damn who you say you are. I'm not letting anybody in the house. I don't trust the police and whoever you are, I don't trust you."

"Doctor, I don't blame you for what you're thinking, but we're here to protect you. My name is Capt. Becker and if you will call Central Police Headquarters, they will verify my story. There has been a threat on your life."

Grace groaned, "Good God."

I spoke up again. "You wait right there and I'll check."

A quick call verified the entire story. I went back to the front door and opened it to face a whole squad of police and plainclothes men led by Capt. Becker, who turned out to be a very good sort.

Three of the police came in with the Captain and we went back to the den. I made apologies for my attitude, but explained that after what I had been through, what with being set up by Lt. Tomlin and the addict Buscemi, Milton Allen and the rest, I trusted no one, especially Police.

Captain Becker said, "I don't blame you and I sympathize with your problem, but I hope you will feel differently about us. We are here to protect you. We've had a threat on your life. Have you received any strange calls in the last hour?"

"No."

He continued, "A call was taken at headquarters and recorded. The voice said 'This is Black October. We're gonna assassinate Dr. Ross Pierpont at 3:30 PM tomorrow at the Maryland General Hospital!' That is all that was said and they hung up. The only thing we have to go on is that the voice was male, almost certainly black and probably young. Do you know anything about this?"

"No. What do you know?"

"Only this. We got similar warnings before the murder of Delegate Turk Scott. We are taking this very seriously. Scott's dead, you know."

"I know. This Black October gang are supposedly black vigilantes, aren't they?"

"Yes," continued Capt. Becker. We are of the belief that this is a very small group of blacks, maybe only one or two,

who have adopted the Black October name, which signifies an avenger. They are supposedly out to destroy the drug pushers and dealers preying on the black community. It makes our work that much tougher when they are not organized. We don't know where to look. It's like a needle in a haystack. It could be anyone."

Grace was beside herself with fear. "What can we do?"

"Be careful. We'll cover you. I'm going to leave two men in the house tonight and we'll patrol the outside of the house . . ."

●

"What is your schedule?" Capt. Becker asked.

I outlined the planned campaign tour of the state and he whistled. "Well we've got the night cut out for us. We'll need the FBI and the State Police. You and Mrs. Pierpont go to bed. We'll cover you. Don't leave the house until my morning men arrive. We'll have two detectives and escorts to the Airport Hotel. After that, the State Police and the FBI will take over. I'm terribly sorry. Good-night." He left. The two police sat: one in the living room and one in the den. We went to bed.

In the morning, we were up early. Looking out, I could spot three cars parked, two in the front and one in the back of the house. Just as we were finishing breakfast, the doorbell rang and one of the policemen let two plainclothes men in. They introduced themselves and explained that they would walk in front and back of Grace and myself as a shield and that we should sit in the back of the car well down and to please not move quickly until they were in position around us. It was pretty eerie. We went out-single-file as directed. We looked like a safari. One detective sat in front, the other in back with Grace and me. As we left the house, one of the cars took up a position in front of the car and another to the rear. We arrived at the Friendship International Hotel without incident. The place was teeming with State Police.

The Police continued to surround me and the area of the press conference. All well-wishers were checked as were reporters, TV personnel, etc. The press conference over, we headed for the airplane covered like a tent with security. The plane in which we were riding was thoroughly searched and checked out for explosives or problems, and Grace and I were held in the car beside the plane while this was accomplished. We were then hustled aboard with Rich Hollander, a *News American* reporter who had requested permission to accompany us, and we took off—much to the relief of the Police.

Our first stop would be Gaithersburg. . . . The runway and small airport lounge were covered with State Police cars and other Police, but only two faithful campaigners and two reporters were there to meet us. We kept up a running fire of conversation and an outward bravado,

Table 2: A Pierpontian Chronology, 1974-78

1974

- March 22nd:** Dr. Pierpont first meets Salvatore Buscemi as patient, in Havre de Grace, Harford County, MD
- March 25th and 26th:** Buscemi returns
- March 29th:** Buscemi visits Baltimore office
- March 30th:** Visits Pierpont home in Baltimore
- April 1st:** Returns to Piermont home and retakes box (TV?)
- May 31st:** Lt. Leon Tomlin calls Dr. Pierpont; presents him with subpoena at Dr. Pierpont's Baltimore office to appear before the Baltimore Grand Jury on June 4th
- June 26th:** Dr. Pierpont indicted; charged with illegal prescription of drugs to Buscemi
- June 27th, 11:45 PM:** Dr. Pierpont meets with Helen Delich Bentley at her home to discuss US Senate race
- June 30th:** Dr. Pierpont retains George Russell as his attorney
- July 1st:** Dr. Pierpont files as a GOP candidate for the US Senate; Mrs. Bentley drops out of the race; Dr. Pierpont put under police protection after his life is threatened by Black October killers
- July 2nd:** Pierpont campaign tour of state in progress as Baltimore judge dismisses the indictment against him for lack of jurisdiction
- July 3rd:** Case goes to Harford County instead; Harford County Grand Jury indicts Dr. Pierpont.
- Sept. 10th:** Sen. Mathias defeats Dr. Pierpont by 75,000 to 25,000 votes in the GOP Primary Election
- Sept. 21st:** Christine Pierpont (daughter) marries German Baron
- Oct. 17th:** Med-Chi Panel of Peers hears Dr. Pierpont's case
- Oct. 24th:** Med-Chi Panel exonerates Dr. Pierpont

1975

- Sept. 16th:** Trial before Judge Albert Close in Harford County; **acquittal.**
- December:** Milton Allen named a judge by Gov. Marvin Mandel; Dr. Pierpont files suit in US Court for the District of Maryland for \$4 million against Allen and Baltimore Grand Jury Foreman Frederick T. de Kuyper for damages for denial of civil rights, liberty and malicious prosecution

1976

- June 30th:** Imbler-Pachtman Decision of US Supreme Court
- July 19th:** Judge Joseph H. Young dismisses Dr. Pierpont's suit in a summary judgment
- Aug. 12th:** Dr. Pierpont's request for Grand Jury Minutes of his case is denied by Anselm Sodaro, Chief Judge of the Supreme Bench of Baltimore City
- Aug. 19th:** Dr. Pierpont files Appeal to US Court of Appeal's for the Fourth Circuit at Richmond, VA for Grand Jury Minutes
- Nov. 26th:** Second Pierpont Appeal presented to Fourth Circuit Court of Appeals for reversal of judgment in favor of Allen and deKuyper.

1977

- Feb. 9th:** Court rules in favor of Allen and deKuyper; Dr. Pierpont decides to go to the US Supreme Court in Washington, DC
- May 9th:** Appeal filed
- June 14th:** Flimflam charges against Buscemi dropped
- June 30th:** Supreme Court refuses to review Pierpont case

1978

- Sept. 12th:** Dr. Pierpont defeated by J. Glenn Beall in GOP Gubernatorial Primary Election

but later I remarked that we were in real trouble if we couldn't shake this drug rap quickly and permanently.

"Lloyd, (Reynolds—a campaign aide—ed. note), we were promised 100 campaigners here this morning."

"I know, Ross, but everybody is uptight. Watergate, Agnew and all the rest of the political corruption has got the public buffaloed. They don't know what to think or do. Unless we can move out quick, we've had it. Well, it's time to go to Cumberland anyway. Let's go."

The Cumberland Airport is actually in West Virginia. The West Virginia State Police were ready for us. As we hit the runway, we could see a row of riflemen lined up along the crest of a hill perched high on a plateau overlooking the Cumberland Valley.

I was out of the plane first and greeted by one lone campaign aide. He was apologetic and related a whole series of calls with excuses from local politicians whose help we had obviously lost overnight. In discussing it, we all agreed no one could blame these people for their caution.

After all, Nixon had said he was innocent. So had Agnew. So had Dale Anderson, the County Executive of Baltimore County. They were better known than I was and, after all, I had been indicted. Herein lies the tragedy of a system which supposedly leaves a man innocent until proven guilty. Unfortunately, with the immediate electronic media and the press, plus the instant glare of publicity, indictment translates in the mind of the average American to guilt. Our plotters knew full well the impact of what they had accomplished and I must confess their plan was working perfectly.

We went into the small airport waiting room accompanied by two West Virginia troopers, followed by two reporters and the one campaign aide. A rather lengthy press conference was held with a lot of good natured give and take with the reporters. We found here we were traveling faster than the news. Much of what had transpired with regard to the death threats, police protection, etc. was news to these reporters from the Cumberland daily paper and a radio station. They were known to me from other campaigns and we had a very pleasant general discussion. They were sympathetic about my legally-imposed inability to discuss the drug problem.

We left for Hagerstown . . . to a similar reception, with no better, but about equal, results. Then we flew toward the Eastern Shore and Salisbury. I looked at my watch.

"Grace, boys. Cheer up. It's 3:30 PM. I'm not dead yet. It's a beautiful day. We're one-on-one on Mathias, and I'm beginning to feel encouraged.

"You should," Rich Hollander answered.

"What do you mean?" I asked.

"I called the *News American* city desk from Hagerstown. Judge Parrott threw

your indictment out late this morning. I thought you knew it."

"Hell, no! How could we know it? We haven't been in touch since this morning. Are you sure?"

"Absolutely" Hollander echoed.

"Hurray for us!" Everybody yelled at once, talking and laughing.

To say exhilaration took over was putting it mildly. The whole picture brightened and we all knew we could look for better days. We landed in Salisbury and again found only two loyal adherents.

The same excuses we'd heard, but this time we could give an upbeat to the occasion by announcing the latest news. The indictment had been thrown out in Baltimore. This was new information to our campaigners as well as the two reporters from the Salisbury news and the local TV station. We continued to travel faster than the news.

During the news conference, I opened up a little bit about the conspiracy to degrade my candidacy and left no doubt in the minds of anyone that our camp was convinced that Mathias and Mitchell had a hand in the activity with Allen. We were all feeling better than we had all day.

State Police were much in evidence and as the conference broke up one of two plainclothes men came over.

"Dr. Pierpont, I'm Raymond Slye, FBI." He flashed a badge of identification. We will be covering you with the city and State Police until we are sure this Black October episode has quieted down."

"Has there been anything else?" I asked.

"No, but everybody's nervous. These people are kooks. They have no pattern. The fact that your case was thrown out is good news, but it doesn't lessen our problem."

"Why?"

"These kooks frequently don't follow any logic. A lot of the time they don't read. Even if they did, in this situation they might get the tilted notion that you got off on a technicality or by political pull. That might make them worse. No, you are not out of danger yet; so give us a break and be careful and we promise to do our job."

"OK. Thank you very much." I concluded. Everyone was a little looser now and wandering around the Salisbury lobby.

I called out. "Let's get the show on the road. Back to Baltimore."

The Police took up sentry posts and out we went single file into the plane and back to Baltimore. It had been an unusual day. There was room for chagrin. We had been dealt a gruesome body blow in prestige and loss of adherents by the indictment and bad publicity, but then there was room for elation. George Russell had gotten the indictment thrown out and we were clear again, and there was room for reflection—lots of it.

Where do we go from here? Has the throwing out of the indictment removed the stain? Indeed can anything ever remove the stain?

It was increasingly obvious that we were dealing with a vicious adversary world and the higher we climbed, the more severe the buffeting. Could we take it? I guess we were all asking ourselves that question. We believed we could.

Campaign Slurs . . . and Defeat

All along the campaign trail we were hit with slurs and innuendos. "The last of the big time drug dealers;" "Where you gonna get your fix tonight, Pierpont?" "Who's your 'French connection?' etc., but with it all, you could feel the strong underlying schizophrenia of Republican Party feeling against Mathias, a feeling that wanted to be palpably for our side. The vast majority of the Republican party of Maryland didn't want a Mathias it didn't trust . . . If only we could break away from the cloud of this Baltimore City drug indictment, we knew we could win.

I was confident Harford County would not return an indictment. So was George Russell.

The analysis by everyone pointed to a cleaning of the slate in Harford County. With this behind us, we felt confident of a tough battle, but a clear victory against Mathias with all of this trash behind us.

In spite of all our best efforts, what passes for justice frustrated us at every turn and we were stuck: exactly what our enemies had planned. They had gained this end.

In spite of all this, and with a drug charge hanging over my head, I pulled 25,000 votes to 75,000 for Mathias in the election. The public did not want Mathias, but could they vote for an alleged drug peddler?

Amidst the Chaos, a Wedding

(During all the criminal proceedings and political campaigning, the Pierponts were busy planning the wedding of their only child—daughter Christine—to a young German Baron. Dr. Pierpont discusses his feelings during this most trying period.)

It was now obvious I was locked in a death struggle with a problem that had already destroyed a Senatorial career, and now ominously threatened my social, professional and personal existence. To make matters worse, I was isolated, and alone.

Everyone wanted to help me. So many constantly reminded me they were in my corner. Friends and associates volunteered advice and comfort. The attorneys kept trying to explain the reasons for the endless delays and lack of action, but with it all, I felt cornered and alone.

This is a difficult experience. In many ways, in outward appearance, everyone except a few seemed to be on my side,

and yet when you sat down in solitude (and I did a great deal of this, watching more and more TV and never seeing it) you could feel the loneliness settle over you like a shroud. Alone in the crowd—but alone nonetheless.

You cannot make anyone understand this unless he or she has been indicted, pursued, frustrated and put on the line . . .

Trial in Harford County

The Bailiff announced "All rise." Judge Albert Close entered and took his seat on the Bench.

The Clerk Announced:

"Criminal Case #5000, State of Maryland vs. Ross Z. Pierpont. The defendant is charged by indictment for knowingly and intentionally prescribing controlled dangerous substances and prescribing controlled dangerous substances.

The State is represented by John A. Goodman, Esq. The defendant is represented by George L. Russell, Esq. and Freeborn Brown, Esq.

On Aug. 24, 1974, the defendant waived arraignment and entered a not guilty plea and requested a jury trial."

"We will waive a jury trial," I responded.

The Judge: "And by the court, thank you sir. And your plea is not guilty to all charges?"

"Yes it is."

The Judge: "Thank you."

Buscemi testified he was 52 years old, living at 4116 Brandon Ave., Baltimore, MD and that he was not working.

Goodman, "Now, Mr. Buscemi, I see Mr. Russell is looking at the FBI report here. We might as well ask you about your record. You have a lengthy record, is that not true?"

Buscemi: "Yes."

"Dating back to what year?"

"I don't know how far back it goes, but I got a bad record," Buscemi testified.

Goodman: "Okay, more than 20 years?"

Buscemi: "Yes, sir."

Goodman: "What are the nature of these various crimes that you admit to having committed?"

Buscemi: "Mostly all narcotics and largely by trick."

Russell interjected, "And narcotics," he said, "Didn't he say narcotics?"

The Judge: "Narcotics and larceny, as I understand, is that correct?"

Buscemi: "Yes, sir."

Goodman: "The most recent conviction, when was that?"

Buscemi: "I guess it was back in maybe '68 or '65, I can't remember."

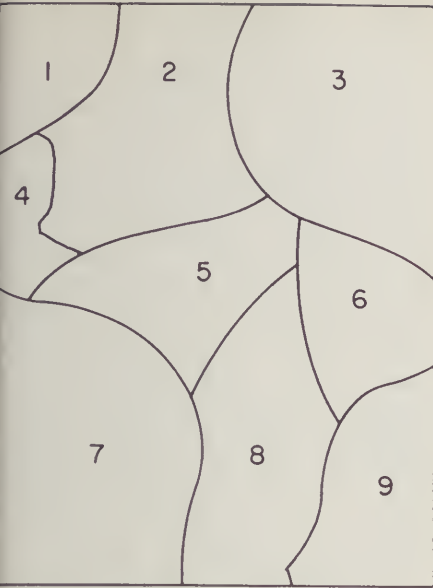
Goodman: "What was that for?"

Buscemi: "Larceny."

Buscemi then gave a lengthy testimony of his visit to the Havre de Grace office. The thrust of the testimony was that he came to the office in search of 100 Dilaudid tablets. His reason given for needing the



(Photos by Rex Webster, Leslie McKay Ryan and Linda Sullivan-Schulte; photomontage design by Claude Brooks.)



(LEFT) DRAMATIS PERSONAE:
1) Tydings 2) Mathias 3) Bentley 4) Mandel 5) Parren Mitchell 6) LBJ 7) Milton Allen 8) EMK 9) Russell.

medication was he was an addict and that he was going to Lexington, KY for treatment at a Federal narcotics center.

He further testified that he was a heroin addict of over 20 years and was in a methadone program at Glenwood Life.

Buscemi testified that he did not complain of pain in his legs the day of the examination, but he did admit to showing his legs to me where scars and recent healing abscesses from drug injections were evident.

He stated that he called the following day, on Monday, and came to my office and I again told him I could give him no Dilaudid and gave him Demerol . . .

George Russell, in cross-examination: "Mr. Buscemi, the State has supplied me with your FBI record and I would like to go over this with you. In 1940, you were convicted of larceny, and you received 30 days in Baltimore City Jail. Is that correct?"

A: "Uh huh."

Q: "In Baltimore, MD, 1954, you were convicted of violation of the marijiuna act and received two years?"

A: "Right."

Q: "In Baltimore, MD, 1954, you were convicted of violating the narcotics laws and received seven years in the Maryland House of Correction, sentence suspended, probation and court costs to be paid, is that correct?"

A: "Yes."

Q: "Also, in 1955, six months for forger; is that correct?"

A: "Yes."

Q: "In Towson, convicted 1961 for violation of the narcotics act for which you received 10 years in the Maryland Penitentiary, which was reduced to three years; is that correct?"

A: "Right."

Table 3: The Cast of Characters

Ross Z. Pierpont, MD:	Surgeon, perennial political candidate (in 1974, candidate in GOP US Senate Primary Election)
Joseph D. Tydings:	US Senator, 1965-71; lawyer
Charles McC. "Mac" Mathias:	US Senator, 1969-present
Parren J. Mitchell:	US Congressman, 1971-present
Milton B. Allen:	Baltimore State's Attorney, 1971-75; Judge, Supreme Bench of Baltimore City, 1975-present
Lt. Leon Tomlin:	Baltimore Police Dept., Narcotics Strike Force
Salvatore Buscemi:	Drug addict, ex-convict, police agent (?)
George Russell, Esq.:	Attorney for Dr. Pierpont
"Black October:"	Gang of killers; murdered State Delegate Turk Scott, a suspected drug dealer
Michael Olesker:	Reporter for the Baltimore News American at the time

Q: "May 19, 1965, you were convicted of grand larceny in Richmond and received one year; is that correct?"

A: "It wasn't grand larceny."

Q: "What were you convicted of?"

A: "False pretense."

Q: "OK. Jan. 18, 1966, you were convicted of larceny by trick and you were

sent to jail; is that correct?"

Buscemi became very agitated at this point and began to argue with Russell.

"It's all there, why don't you read it?"

Q: "September, 1966, in Baltimore, you were convicted of false pretense; you got five years, correct?"

A: "That is right."



SEPT. 21, 1974: THE WEDDING. (From left to right) Dr. Pierpont, daughter, daughter's husband and Mrs. Pierpont. The smiles covered a tension that all felt.
(Photo courtesy of the Pierponts.)

Q: "May 6, 1961, convicted of shoplifting—\$100 and costs, correct?"

A: "Yes."

Q: "You stated under oath today, nobody promised you anything?"

A: "Right."

Q: "Did Mr. Goodman promise you anything?"

A: "No sir. I just met Mr. Goodman this morning."

Q: "I'm very glad to hear that. Did Lt. Tomlin promise you anything?"

A: "No, sir."

Q: "Did Milton B. Allen promise you anything?"

A: "No, sir."

Q: "All right, now tell me where are you? Are you out on bail now or are you in jail?"

A: "I'm out on bail."

Q: "Now, where and when were you in jail—beginning from today back?"

A: "I was in the Baltimore City Jail."

Q: "How long?"

A: "Well, I was in Howard County and Baltimore City Jail all told, two and a half months."

Q: "I notice your hand Mr. Buscemi. Isn't that sclerosis?"

Buscemi stalled.

Q: "Isn't that venal sclerosis?"

A: "Yes, this is from using drugs. What are you trying to say?"

A: "I am just asking you a question!"

A: "Yes, you are right, you know, the many cases you handled."

Q: "I know. Now you have that all over your body, don't you Mr. Buscemi?"

A: "Yes."

Q: "Is there any part of your body that does not contain the sclerosis, other than your face?"

A: "Yes, sure it is!"

Q: "Is it in your feet; is that correct?"

A: "Yes."

Buscemi became very agitated and objected to Russell's questioning, but Russell bored in. Goodman objected.

Russell to Goodman: "You stipulate that he has venal sclerosis all over his body, and I won't make him take his clothes off."

Goodman: "I don't know the relevance of whether he has it over 70 or 80%!"

Russell: "If I, as an untutored person, can recognize venal sclerosis, certainly a physician can!"

Goodman: "I am not disputing it."

Russell bored in again: "OK, do you know that your eyes indicate heroin addiction?"

A: "Sure, I know it."

Q: "So you realize that a trained person can look in your eyes and know you are a drug addict?"

A: "Right."

Russell pointed out to Buscemi and the court Lt. Tomlin's solicitude for Buscemi's welfare. He showed Tomlin getting Buscemi out of jail. He accused

Tomlin of "judge shopping" in Baltimore County for Buscemi to get bail and stetting of cases. There was no question in anyone's mind when Russell completed this line of questioning that a serious, nefarious, unsavory relationship existed between Lt. Tomlin and the Baltimore City Police Department and this con man, admitted narcotics addict and larcenist, Salvatore Buscemi.

Tomlin testified he had been with the Baltimore Police for 15 years with eight years in the Criminal Investigation Division narcotics unit. He had known Buscemi 12-14 years and repeatedly denied making him a deal for his testimony . . .

The Journal Introduced as Evidence

Later in the trial, Mr. Russell questioned one of the State's physician witnesses: "Would you read the *Maryland State Medical Journal*, August, 1974, page 17?"

The witness read aloud: "New Federal Statute took effect on May 18, 1974 which prohibits a physician from maintaining an addict on any opiod for longer than 21 days without filing an application for the operation of a drug program for the treatment of addicts. Any physician who may be prescribing or dispensing for addicts for longer than 21 days should assure that he is in compliance with the Laws" . . .

Russell moved for acquittal. He pointed out that the State's two experts had literally exonerated me. He pointed out there was no motive for profit, having only collected \$15 for a first visit and still being owed \$10 for the second. Russell further pointed out the character of Buscemi and Tomlin versus the character of Pierpont and many other cogent points . . .

At Long Last . . . Acquittal!

(From the trial transcript, Judge Close concluded:

"All right, gentlemen, I think if you will recall, that in ruling on the motion, the Court decided that indeed someone outside of the medical profession, whether it be a judge or a jury, instructed by the judge, could decide whether or not the doctor had—within the language of the act, acted in conformance with the standards of the medical profession, and we simply said that in arriving at some decision with regard to this issue that we judged it by the conduct of the doctor measured in the light of common understanding and practices. And to enable a court or a jury to understand what the common understanding or practices are, we call on people in the medical profession to help us, and that is exactly what happened in this case, and it doesn't seem to me, sitting here, having listened to the adversaries, whose adrenalin is up, that it may be exactly what you feel it is on each side. The State's witnesses . . . both had some difficulty in saying for certain that this particular defendant, who is under what we call a common practice, and not

the proper practice, had done anything that was not in accordance with the common practice. And, of course, they had not heard all of the testimony in the sense that they had not heard the defendant's side of the case.

"Now, I want to say that this is a very serious matter, not only to Dr. Pierpont, but also to the medical profession who have come late, so to speak, in the writing of the rules of conduct, as compared to the legal profession, which has for years gone by had a code of professional ethics. And I say this only because I was involved in the Collahan case, and it seems to me that there about began the time when the Medical and Chirurgical Faculty did adopt some rules, which later became codified in the laws of the State. And here again, we separate the criminal charge from the professional conduct aspect of this thing in the same way we would with a member of the legal profession.

"Now, I am not so certain in my own mind that if there had not been a display in Baltimore City which gave rise to a great deal of publicity across the land with regard to this particular defendant, who is prominent in his profession, but also is a public figure, that perhaps there might not have been an indictment in Harford County had the thing been initiated in the beginning, on the basis of what the Grand Jury might have heard. And, of course, I don't know what they heard, but I know what I have heard, and I think that a great burden fell on the Grand Jury, the State's Attorney's Office here, and I certainly want to commend Mr. Goodman, who I know is really not enjoying greatly the fact that he is required to participate in this case, nor perhaps is Mr. Russell, but I don't find beyond a reasonable doubt and to a moral certainty, from the evidence that I have heard, that the defendant in this case did not act in accordance with his regular professional duties under the first count, knowingly and intentionally in prescribing the drug in this instance, or two instances, three if we take on the Demerol. Nor do I find with respect to the second count that it is surely beyond a reasonable doubt and to a moral certainty that he was not in conformance with the professional standards. And, God knows, I don't think I am qualified, really, to say whether he was even careless, or used bad judgment. His peers have expressed themselves on that, so the Court finds the defendant not guilty under each count of the indictment.

"I want to commend counsel, really, in this case for their fairness with which they have conducted this inquiry. And I guess that perhaps this may be really the first inquiry of this type, under the statute, and I could be wrong as rain, for that reason, but I'm only going on what my visceral feelings may be, along with whatever evidence was adduced before me. Thank you very much. (Whereupon, the trial was concluded.)

(Dr. Pierpont was acquitted. He resumes his narrative.)

I jumped up and thanked the judge and bedlam broke out in the courtroom. Russell and Freeborn Brown were congratulating each other. Grace leaned over the rail and hugged and kissed me . . . Friends cascaded out of the spectator area to surround all of us. Brooks Bradley, an old mortician friend from Dundalk, and John Conway were slapping one another and me on the back. It was a happy scene . . .

Squeezing thumb and forefinger together, I said "We were that close to medical, personal and public oblivion."

Grace was crying . . .

It was finally a brilliant happy ending to the most sordid episode of an active lifetime. Now to deal with the connivers who perpetrated the act. Could justice really be done? We would see, but from the other side of the coin!

Some Reflections on US Justice Today

(Later that day, Dr. Pierpont revealed his intentions to countersue Allen and Tomlin to his wife, Grace, explaining:)

"There is general tragedy and malaise in justice over the country today and we're at the vortex of it. What I'm driving at is our dual system of justice. I'm sure if I had been some liberal, everything would have been dropped immediately, but I'm branded as a conservative. All conservatives are fair game for the liberal warped prosecutors in today's justice system. They have a complete double standard. If this were not so, how is it that the liberals are never prosecuted?"

"What do you mean?"

"You want examples?"

"Yes."

"Well, first let's just list a few. Teddy Kennedy. Practically every thinking person suspects murder at Chappaquidick with the death of the Kopechne girl. Where were the prosecutors? Why wasn't she autopsied? Why wasn't Kennedy tried? Why did he pay the Kopechne hush money? Then Lyndon Johnson, what about him? Why did the US Senate let Bobby Baker plead guilty and disappear to jail? He got a very light sentence. Why not a Senate investigation? This would have made Watergate look like a second-rate cops and robbers game, which it was. Probably half the Senate would have gone to jail. While on the Johnsons, how did Lyndon and Lady Bird get so wealthy? Why no official investigation? They did it all on a public salary. Then what about good old Hubert Humphrey? He got caught with his arm in Gulf Oil money up to his shoulder blades. But what happened? The liberal prosecutors and press just turned their heads and said Hubie needed the money. It was a different story with Hugh Scott. Press and prosecutors wanted to railroad him out of the Senate. He resigned . . .

Grace interrupted, "But weren't those people guilty? Agnew, Anderson, Alton, Jones and now Mandel, Kovens and Hess?"

"In a sense, yes, Grace, they were all guilty, but then so was every other official in public office that you and I have known. All were guilty of one problem or another of what these people have been charged with or proven guilty of; the granting of favors in exchange for support or sustenance. But the problem is this, why only the conservatives persecuted and prosecuted? This double system of justice is not happenstance.

I continued: "I've done a lot of thinking. I don't condone any of the bribery, shakedowns, etc. You know how I held press conferences in Kovens' store in 1971 running against Don Schaefer and detailed all of the things they are bringing out in Mandel's trial, not as crime, but as iron-fisted political control by Kovens.

I argued against giving Irv Kovens that same iron-fisted control over Baltimore City that he had over the State of Maryland. The liberal press wasn't interested . . .

The Countersuit

We filed the suit in December, 1975. There was a flurry of activity in the press for a short period, principally caused by the fact that Milton Allen was now a Superior Court Judge of Baltimore City, Judge Milton Allen, by appointment of Gov. Mandel.

I had been successful in persuading Mandel not to appoint Allen for several months. Finally, the pressure of Parren Mitchell, coupled with Mandel's needing sympathetic jurors for his upcoming trial on charges of bribery, overcame all objections. These charges against Mandel were coming through the radically-controlled US prosecutor's office of Baltimore City and the trial would be in Baltimore. Favorable sentiment was necessary for Mandel, Kovens, Hess and Rogers.

In fairness to Mandel, he gave me the courtesy of a call just prior to the appointment of Allen and literally apologized for the necessity of such an appointment to the bench, but such is politics and justice. The liberal newspapers applauded this appointment.

Meanwhile, the Supreme Court's Imbler-Pachtman Decision . . .

This, unfortunately, had come down on June 30, 1976 while a judge had our problem under consideration. Imbler-Pachtman literally guarantees absolute immunity and lack of accountability to prosecutors.

As an example, anyone of you reading this can be indicted, tried and jailed by any prosecutor or assistant prosecutor, knowingly and wilfully using liars, thieves, entrapment and trumped-up evidence. You can prove all of this beyond any reasonable doubt, and yet, under the Imbler-Pachtman decision of the Supreme Court, the prosecutor or State's Attorney is immune from redress. Such is today's

tyranny in the Courts and prosecutor's offices in this US!

(Ultimately, Dr. Pierpont carried his case to the Supreme Court of the US, which notified him on June 30, 1977 that it would not review it, meaning that he'd lost his countersuit. Despite the fact that the Baltimore City Grand Jury notes relating to his original indictment revealed the fallacy of the State's 1974 case against Dr. Pierpont—the same case it would later lose in the Harford County trial—the Supreme Court decided that its earlier Imbler-Pachtman decision guaranteed prosecutors, etc. immunity from prosecution themselves. Dr. Pierpont takes up the story:)

This was expected; however, it was necessary to make the entire effort to obtain justice, otherwise our liberal civil rights advocates could always say we hadn't gone far enough in the system.

We had now thoroughly tested the system from it's shabby, politically-controlled, corrupt beginning, through the various political judicial protective associations, to the bitter end.

You would hope for a progressively-enlightened, more intelligent approach to justice in your progress through the upper echelons of our criminal justice and judicial systems. Depending upon your problem, there is serious question from a practical standpoint whether this occurs.

Certain questions are obvious. Is it possible to obtain justice in this United States today? . . .

We must conclude that justice for the prominent, well-to-do, white man is very elusive. If the individual is conservative and politically active as I was, justice, except as I finally barely escaped with my hide, is nearly impossible . . .

On the other side of the judicial coin, in today's market, the liberal and the penniless have the best of it. Why is this true?

The general guilt complex, which swept through the nation following the civil rights movement successes, is now very prominent among today's judiciary and criminal justice systems. Everyone bends over backwards to make sure the liberal and the penniless are given every consideration and break possible. This warping was bound to occur.

As an example, an Angela Davis goes free, but a Patricia Hearst has great difficulty. Of course if you are big enough to corrupt the system completely, you can be white, as in the case of Sen. Ted Kennedy at Chappaquidick. They didn't even autopsy the girl, much less tear holes in a Swiss cheese story, but here we are dealing with a white liberal, and in such hands if the individual is high enough and rich and powerful, the bending of the system can be accomplished. In this instance, it was.

What is the significance of all of this to the average citizen?

The judiciary of this nation and their controlling position within the criminal justice system represent the last bulwark

between the citizen and tyranny of the State.

If the judiciary, for whatever reason, fails in its even-handed administration of justice, we are face-to-face with State tyranny. This is indeed tyranny of the State by the judiciary and therefore under the law.

These are frightening concepts. With the Imbler-Pactman decision, these concepts have indeed become truths. Our Supreme Court has literally decreed tyranny of the State by the criminal justice system. We must now depend on the integrity of each and every prosecutor and his assistants in this nation.

What will happen under someone disposed to silence opposition?

With properly-utilized and rewarded State's Attorney's, the opposition can be silenced.

You say it can't happen? It happened to me. It happened to Imbler. It has and is happening to others.

What can be done?

Some way, somehow, the Supreme Court must be persuaded to rescind the Imbler-Pactman decision. It is bad enough that the judicial and legal buddy system makes the bringing of a lawyer, judge or prosecutor to task for injustice nearly impossible. It defies all reason that prosecutors should be added to judges as sacrosanct individuals with no accountability for their individual actions.

What about justice?

I really don't know. Do you?

Epilogue

The long search through human history for equitable justice has been one of infinite difficulty. On the one hand, it is necessary to have an orderly society while constantly attempting to protect the individual liberties of each citizen. In this conflicting environment, equitable justice frequently hangs finely in the balance.

Our efforts in the US to turn the courts of our nation into a quasi-everyday revision of legislative decision-making and the recent readiness of the court to accept this role (and indeed to "discover" in the constitutional text a basis for detailed legislative precepts in a variety of fields) is bound to lead to a distortion of the division of powers. This activity is rooted in the assumption that fundamental rights of the citizen are constantly endangered by their elected representatives, and that judges who have been selected indirectly or by inter-party compromise represent a "superior" kind of objectivity compared with representatives of the people elected on the basis of an openly proclaimed political program.

This is bound to discredit the democratic process whose results are subordinated to a "non-partisan" interpretation of the law, and to blur the delicate but vital borderline between the necessary review of a democratic decision under the rule of the law and this gradual replacement by the transgressions of a "rule of judiciary." Finally, this discredits the judges themselves, increasingly tempted into political

judgments, pronouncements and decisions beyond their competence.

Thus, we see the judiciary of our US overreaching the conceptual bounds of our democracy attempting to fulfill aims beyond the responsibility of the judiciary and, in point of fact, becoming oppressive to the very society it serves. What may start as individual oppression could extend rapidly to engulf large segments of our citizenry.

With the existence of a problem of this magnitude, the salvaging of an occasional malicious prosecutor is not worth the price of a possible oppressive society—as exemplified by the Imbler-Pactman decision.

The means to control such an activity are at hand in Congress of the US. Laws must be enacted to contravene Imbler-Pactman-type decisions, and consideration must be given to laws to question the absolute sanctity of judges. Oppression by any branch of government is intolerable in a free, democratic society.

An examination of the operation of the Narcotics Strike Force under Mr. Allen and Lt. Tomlin is interesting. These two used \$800,000 in LEAA Federal funds over a three-year period and had involved over 100 physicians before the Baltimore City Grand Jury. With the uproar over my indictment, this number for indictment dropped to 10. Upon my acquittal—and my willingness to testify against Allen, Tomlin and Buscemi—the present Baltimore's City State's Attorney, William Swisher, dropped all charges against all physicians.

This Narcotics Strike Force expended several millions of our tax dollars and didn't get one conviction.

Postscript . . .

(On June 14, 1977, the Baltimore *Evening Sun* carried the following story, entitled *Eight Flimflam Counts Are Dropped*:)

"The Baltimore State's Attorney's office has dropped eight flimflam charges against Salvatore L. Buscemi, a reported informant prosecutors kept out of jail for 28 months despite a continuing string of arrests.

"Buscemi, 53, a convicted flimflammer and drug addict and former scion of his family's now-defunct sausage business, is

in City Jail awaiting trial Aug. 12th on two other flimflam charges dating back to last year.

"He surrendered to the City Sheriff December 14th a few days after a bench warrant was issued for his arrest on a probation violation charge by Chief Judge Anselm Sodaro of the Supreme Bench.

"The dropped charge involved about \$1,100 worth of alleged loot from flimflams dating back to the summer of 1974. They were dropped in return for Buscemi's testimony as the State's key witness during the 1975 drug trials of Dr. Ross Z. Pierpont, who was acquitted.

"Prosecutors agreed to drop the old charges and had gotten Buscemi a suspended sentence on a trespassing charge in early 1976, but cut off further intervention in his behalf before he was arrested on the later charges.

"The two open charges allege that Buscemi bilked a Riviera Beach woman out of \$400 for two color TV sets that were never delivered in April, 1976, and allege that he was the accomplice of a woman arrested for taking a \$60 payment from a plainclothes state trooper for another TV set in October, 1976."



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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

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Part 3: A Doctor's Political Life:

An Exclusive Interview with Ross Z. Pierpont, MD

By BLAINE TAYLOR

His Candidacies

Why have you run so many times?

Well, I've always run with very specific purposes, and I've **not** always run because I thought I could **win**, particularly, but felt that my running would be a material factor in someone else **not holding** that office, which I thought at the time was terribly important.

In 1966, the drift to the political left in the Democratic Party had been very marked. In the Democratic Gubernatorial race that year, there were seven candidates running, and the principal ones were George Mahoney—who **did** win and become the nominee—and Carlton Sickles. There were three conservatives opposed to the very liberal Sickles, an advocate and personal friend of the Tydings-Kennedy combine of left-side liberalism. I thought that, unless **something** was done to obviate that, Sickles would win. I felt that Sickles' winning at that time in the Primary would've been tantamount to election in the General. Another part of this was that I was very close then to Ted Agnew. We were playing golf together. Actually, I didn't decide to get into the race until late in June. I realized that, in the minds of the public, the terms "black" and "liberal" meant the same thing. My feeling was that, if we could formulate a black-white ticket—which made sense, anyway—and run across the state with it, it would be helpful. If we ran well in black areas especially, I felt we might well give Sickles problems enough that he would lose. I was, therefore, the first person statewide to run shoulder-to-shoulder with a black candidate . . . in that case, Archie Williams, who ran for Comptroller.

On that premise, I went to the black community—to the late Dr. Carl Murphy, publisher of the *Afro-American Newspapers*, to Jua-

nita Jackson Mitchell from the civil rights movement and to two or three professors at Morgan State University—in an effort to present a black-white ticket to the state. They selected Archie Williams.

We only got 4,500 votes, but they were all votes in key areas where Sickles needed them. Mahoney beat Sickles by 1,800 votes. In one key precinct in Anne Arundel County where Sickles was beating me by 20 to 1, there were a thousand votes where the levers didn't register for either Sickles or myself. We both challenged for those votes—so, they were thrown out. That would've put him within 800 votes of Mahoney had Sickles won those votes, and I believe they would've counted George out in the recount. That was the end of Sickles' elective career when he lost.

Ted Venetoulis of this past year's race was in his camp, too. I supported Agnew in the General Election.

1968

In 1968, I ran as a Democrat against the incumbent US Senator Daniel Brewster, in which I polled some 40,000 votes. I didn't want Brewster to be reelected. I'd asked several other people to get in the race, but nobody would. It was obvious at that time—and the *Journal* carried the story later—that Brewster had a problem with alcoholism. There wasn't any question in my mind that he was disabled by this.

In the 1968 campaign, one of our ads said that "We pledged sober thought," and this elicited great yelps of pain from the Brewster camp because they claimed we were saying he was a drunk! I didn't think Brewster was a satisfactory Senator. He wasn't doing the job and should be replaced, I felt.

When Brewster defeated you in '68, did you support him or Mathias in the General Election?

I supported Brewster because I

found Mathias extremely wishy-washy. In talking with Brewster after the Primary, I found that he'd straightened himself out a good deal. He wasn't drinking and looked well.

The 1968 race was the time I really got to be known around the state, as I spent \$250,000 of my own money and an additional \$160,000 of other money in the campaign.

Money Spent

How much do you think you've spent in total in all your campaigns over the years?

Around \$450,000.

Is it a true statement to say that you're a millionaire?

I think it's fair to say. The newspapers all say it! Yes, I've made some money—worked hard and been successful. I've done all right that way. Money's not been the problem. I've spent it in the political game. I've gotten alot out of the country, and I've given alot back to the country.

That's one of the reasons I've run. I've felt very strongly about trying to put this nation together. Through this entire thread, I've been a "Proposition 13" type of individual **against government** spending and **for** fiscal responsibility and **for** the great necessity to operate on a prudent fiscal basis so we don't become strung out like so many democracies have in the past and lost their identity by going bankrupt. You have no friends when you're broke! The US will be no different. All the "friends" we think we've bought will leave us very promptly!

A Spoiler?

Would you call yourself a spoiler, in that you go into races not necessarily to win yourself, but to defeat someone else?

I guess that's a proper connotation, but I'd rather think of myself

as an activist in pursuit of principles in which I believe. I oppose those who **don't** hold those principles.

Changing Parties

Why did you ultimately decide to become a Republican?

I finally left the Democratic Party when I saw the McGovern business coming about—the terrible debacle of left-side extremism within the Party. I saw that the only sensible way was to support people who could manage the country—people who had their feet on the ground considerably more than the Democrats, and that led me to the Republican Party.

The 1970

Anti-Tydings Campaign

Let's talk about the Tydings race in 1970.

As I said, in 1968, I was concerned about defeating Brewster for reelection. Even **more** than that though, I was concerned with the advent of 1970 Tydings activity.

Because of **that**, I was very interested in getting around the state in anticipation of the '70 race. During 1968, I found out something that no one else really knew.

Everyone thought that Tydings was unbeatable in 1970, but everywhere I went—from Western Maryland to the Eastern Shore—the Democratic leaders said to me "We know everything you're saying about Brewster is true, but he's never done us any harm, even though he's not done us much good. We're not going to hurt him. You come around in 1970 when Tydings runs, and we'll be with you 100%."

Why didn't they like Tydings?

Not only didn't they like him, they actually **detested** him! It was amazing! I was even surprised myself at the depth of feeling **against** Tydings. They didn't trust him at **all**, they felt he was totally lacking in integrity, was out for himself, was a climber and was using them purely and simply to further his own ends. He let everybody down and ran roughshod over them when it suited his own interests best.

How do you find Tydings as a person?

I was Joe's personal family surgeon. I knew him very well. We fell out when he backed the Baltimore bankers, who were at one time interested in keeping blacks out of the downtown sector in the late 'Sixties, although many of them now would deny that. Some of us had designed an anti-poverty bill that was on Sargent Shriver's desk in Washington for signature and Tydings killed it on the behest of the bankers, whose financial backing he needed in 1970.

Do you think he was a phony liberal?

Yes. It was just a facade that meant nothing.

What do you think Tydings' "own interests" were?

He hung around with the Kennedys. He thought he might be Vice Presidential or Presidential timber or whatnot. He was totally bent on climbing upwards.

Originally, I had the complete approval of the Democratic machine to run against Tydings, but I realized that I wasn't sympathetic to the way the Party **itself** was drifting—leftward. After examining at length my own conscience, I asked a number of my Democratic supporters if they'd still back me if I switched Parties and ran as a Republican. They said they would. I think I could've won that seat in the Senate in either Party's Primary, because of my well-known independence.

I then saw Rogers C. B. Morton—the Chairman of the GOP National Committee—who showed me polls stating that Tydings couldn't be beaten. They weren't even going to run anybody against him! They were anxious that I become a Republican when I said I would. That was in August, 1969, when J. Glenn Beall—then a Congressman—said he wouldn't run against Tydings.

In January, 1970, I saw them both again and they said they'd back me if I changed Parties, but they said it was hopeless anyway. I changed in February. We organized the Citizens Against Tydings and, in six weeks' time, turned those polls from "can't lose" to "can't win!" In May, 1970, Morton told me—after I'd burned my bridges behind me—that Nixon

wanted to run Beall against Tydings. We had a bitter confrontation over it.

They wanted **me** to run instead for Congress against incumbent Clarence Long, which was a hopeless thing.

Why did you?

They promised me \$100,000 for that campaign, but I only got \$6,000. Even though I lost, I got more votes against Long than anyone else ever has. The most important thing to me, though, was that Tydings be defeated, so I didn't want to run against Beall in the Primary, as I felt it would help Tydings win in the General. I think I would've made a good Senator, but I'm more interested in the country than in myself.

On the Kennedys

I gather from the tone of what you said earlier that you were partially against Tydings because of his ties with the Kennedys. Don't you like them?

I don't **trust** them—and I think with good reason! They're advocates of much social change, and socialism itself is great for those who have everything, because nobody else can reach them. It's an ideal gambit for the man on top. They've been opportunistic. With the tremendous amount of money they have, they control the media. It's rumored they spend \$20 million a year for this across the country. If you don't notify the press about something, they don't look for you—and the Kennedys' notification is ample.

I think they're relatively dangerous to our people to this country.

What kind of a President do you think Robert Kennedy would've made?

Dangerous—very dangerous! He was a megalomaniac of the worst sort. The Kennedys approach the baser concepts of people—the poor and the inept—and promise them everything. Well, that's fine to do and looks great, but if the Republic collapses because of it, is it a good plan? I doubt it.

Do you think that will happen?

I think it's showing some very bad cracking in the seams now, al-

though I hope it doesn't. We have reason to be concerned, however.

What about John Kennedy—do you think he was that bad a President?

He was the best of the Kennedys. As for Ted, I think school has to be out on the Chappaquiddick incident. My goodness! If that had been anyone of us, we'd still be in jail up there trying to explain why we didn't have an autopsy and how we managed to subvert it. That's an open book.

I do get a big kick out of him in his Senate judicial work in which he's advocating uniform punishment for everyone! That's rather ironic! He used every position that he and his family had to bury the Chappaquiddick evidence.

Chappaquiddick

Now wait a minute. He went to trial. He was charged with a traffic violation—a misdemeanor—pleaded guilty and lost his license to drive temporarily. I've read the entire transcript of the trial. The State's Attorney there did not request an autopsy in that case until after the body of the girl had been removed by her family to her native Pennsylvania. By the time he did, they'd buried her and refused to exhume her. The State's Attorney was not a Kennedy supporter and, in fact, in the previous election, Ted Kennedy had campaigned against his reelection, so certainly there was no love lost there between them.

Well, I don't know just how they worked it.

But you just have a feeling that they did, right?

Well, we've all been around too long to know that—with all that power going on—they got that body away. A considerable sum of money changed hands—what was that for?

I don't know that that happened.

Well, had the accident occurred in Maryland, there's no way anyone would escape an autopsy forthwith within a short time!

Yes, I know. Dr. Russell Fisher—the State Medical Examiner—told the Journal that in an interview published two years ago.

A tremendous cloud remains over these people.

If Chappaquiddick hadn't happened, you'd still be against Ted Kennedy, wouldn't you?

Not necessarily, but I think it's a defect in his character. There's also his cheating record at Harvard University. I think he'll do anything to get himself ahead. He's not one to be admired or entrusted with the US' business. I don't trust the Kennedys basically because of their latching onto socialistic issues which they don't indulge in themselves, considering the opulence of their lives, their tremendous holdings, tax-protected monies, etc., and, yet, they advocate all of this suppression for everyone else.

The 1971 Mayoral Race

Why, in 1971, did you run against Schaefer for Mayor?

The Republicans had no one else to run! In that race, I ran again with a black running mate for Comptroller, Mrs. Margaret Dyer. We spent \$135,000 and Schaefer spent \$785,000. Schaefer has been a hard-working Mayor, but he's bullheaded and can't control his bureaucracy, like any Democrat.

The 1974 Mathias-Mitchell-Allen "Conspiracy"

In your book, you allege a conspiracy against you by Sen. Mathias, Congressman Mitchell and Milton Allen. Knowing all these people myself, I find this premise hard to believe, nor do I feel you were that important to them in 1974. I don't see that you were that great a threat to Mathias to necessitate such a "grand alliance." What's your reaction?

I think some of it was happenstance, as so many things are, but not all of it, as the book points out. I don't think they had a grand meeting to disable me or Helen Bentley. Mathias never stated during the entire campaign that he didn't believe the drug charges against me, however.

Had you won the GOP Senate Primary in 1974 over Mathias, do you seriously believe you could've defeated Democrat Barbara Mikulski in the General Election?

Yes. She wasn't well-known then statewide, whereas I'd been around the state three times.

Do you still want Tomlin and Buscemi indicted for perjury?

I did, yes.

The 1978 Gubernatorial Contest

You played a significant part in defeating Glenn Beall for Governor last year by bringing up—even more than Democrat Harry Hughes did later on—the 1970 Nixon money scandal in which Beall was involved. Did you want Beall to lose the General Election?

That wasn't the point. I didn't think he could be elected. I didn't want to run, but wanted Robert Pascal to run instead. He wouldn't, so I got in.

Future

Are there going to be any more Pierpont campaigns?

Oh, I don't know. They call me a "perennial candidate," but I've only been at it for 12 years. We've made so much racket that everybody thinks we've been here forever!

Thank you, Dr. Pierpont. ☐

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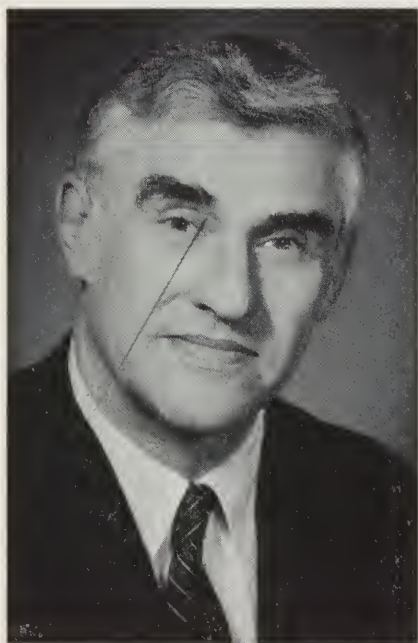
Doctors in the News

Dr. Gunning Appointed Medical Director at St. Agnes Hospital in Baltimore

Jean-Jacques Gunning, MD has been appointed to the position of Medical Director at St. Agnes Hospital in Baltimore. In his new capacity, Dr. Gunning is responsible for medical affairs and patient care and the coordination of medical education as it relates to the post-graduate programs in medicine, obstetrics/gynecology, pathology, pediatrics and surgery.

Dr. Gunning, a native of Baltimore, received his Medical Degree from the University of Maryland's School of Medicine in 1954, after obtaining his undergraduate AB degree from Loyola College in Baltimore. He served as a senior intern at the San Diego Naval Hospital in California, completed his residency in medicine at the US Naval Hospital in Boston, and is certified by the American Board of Internal Medicine.

Prior to assuming his new post, he served as an Associate Professor on the Clinical Faculty of the Department of Internal Medicine and Infectious Diseases at the Univer-



DR. GUNNING

sity of California's (Los Angeles) Harbor General Hospital. Dr. Gunning was the health care coordinator for Indo-Chinese refugees at Camp Pendleton, CA, and is currently an Associate Professor at Louisiana State University Medical School in New Orleans.

During his assignment at Camp Pendleton, he served as Director of Clinical Services and Chief of Medicine, and as Chairman of Graduate Training of the US Naval Regional Medical Center.

In 1971, Dr. Gunning was a delegate for the US to the Southeast Asia Treaty Organization Medical Planning Conference at Bangkok in Thailand.

During the late 1960s, Dr. Gunning's naval medical career took him to the Republic of Indonesia, the Republic of China and the Republic of South Vietnam. While in Vietnam, he served as Chief of Medicine with the US Naval Support Activity Hospital in DaNang.

In addition, Dr. Gunning has served as the coach of the Ocean-side Swim Club in California, and as an American Athletic Union (AAU) swimming referee in the Pacific Southwest Association.

He holds memberships in the AMA, the American Society of Tropical Medicine and Hygiene, I Corps Medical Society, Taipei International Medical Society, Federal Health Care Executives Institute Alumni Association and the Alpha Omega Alpha, National Honor Medical Society.

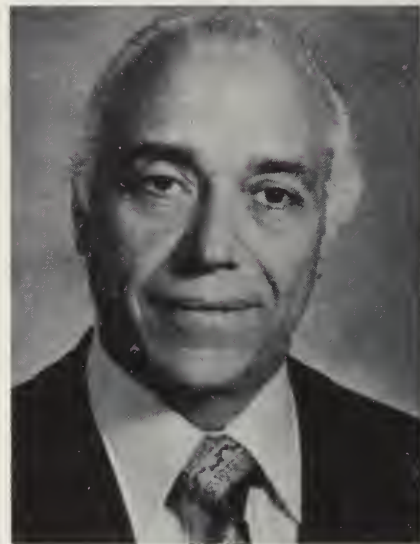
Dr. Gunning was awarded the US Naval Meritorious Service Medal in 1976, the Community Service Award from the City of Oceanside, CA in 1973, the Armed Forces Legion of Merit Award with Combat V in 1969 and in 1968 received a Meritorious Diploma from the Instituto de Medicina Tropical, Sao Paulo, Brazil.

Dr. Gunning has assisted or personally published over 20 publications. He resides with his wife and three children in the Pinehurst section of Baltimore.

Dr. Hardy as President

Cyril G. Hardy, MD took office as President of the Montgomery County Medical Society recently.

A native of England, Dr. Hardy is in the private practice of psychiatry in Silver Spring. He graduated from St. Bartholomew's Medical School at the University of London, and interned at White Memorial Hospital in Los Angeles. He did his residency in psychiatry at Eastern State Hospital in Virginia and Crownsville State Hospital in Maryland.



DR. HARDY

Dr. Hardy served on active duty in the US Navy Medical Corps. He became Chief of Staff at the Washington Adventist Hospital on Jan. 1, 1978, and is currently on the Active Staff there as well as Holy Cross, Montgomery General, Prince George's General and Leland Memorial Hospitals.

Other officers installed were John A. McCormack, MD as President-Elect; Howard I. Levine, MD as Vice President; Joseph Snyder, MD as Secretary and Henry M. Wise, Jr., MD as Treasurer.

Dr. Reichel Named President

Dr. William Reichel, Chairman of the Department of Family Practice at Franklin Square Hospital in Baltimore County, took office as President of the American Geriatrics Society at the 36th Annual Meeting of the Society on April 23, 1979 at the Mayflower Hotel in Washington, DC. □

The Low Iodine Thyroid Uptake: Normal T Dilemma

27

By DAVID J. SEFF, MD

Dr. Seff is Director of Nuclear Medicine of the Church Hospital Corporation, Baltimore 21231, where he can be contacted for reprint and other data.

Introduction

Exogenous iodine in food, drugs and radiographic contrast media is known to increase the circulating iodine pool and to spuriously reduce the I^{131} uptake to values in the range of hypothyroidism.

Acute thyroiditis is an acute inflammatory process with fever, elevated sedimentation rate, tender thyroid gland and extremely low I^{131} uptakes. In chronic thyroiditis, iodine trapping is usually normal, but the organification dysfunction frequently results in a low I^{131} 24-hour uptake. Thyroid antibodies, when present, are diagnostic.

It is, therefore, apparent that the low I^{131} uptake study alone cannot differentiate exogenous iodine interference from the various causes of hypothyroidism and thyroiditis. As will be discussed, a thyroid profile, with T_3 , T_4 , T_7 , TSH and response to TRH and TSH stimulation will ultimately clarify the etiology of the low I^{131} uptake.

•

The thyroid uptake of a standard dose of radioactive iodine is a physiological measure of thyroid function. In normal subjects, the feedback mechanism from the hypothalamus and anterior pituitary gland regulates I^{131} thyroid accumulation in response to circulating thyroid hormone and iodine pool homeostasis.

The clinical potential of the thyroid uptake in measuring thyroid function and thyroid gland affinity for radioactive iodine has been apparent since the pioneer work of Seidlin, Hertz and Ariel in 1940.¹⁻³ Under the influence of TSH, the thyroid gland traps and organifies iodine with tyrosine resulting in the synthesis and release of thyroxine into circulation.⁴⁻⁸

Subsequently, thyroxine (tetraiodothyronine) or T_4 bound to thyroid binding globulin (TBG) undergoes peripheral monodeiodination to its active metabolite 3, 3', 5, triiodothyronine (T_3) or to 3, 3', 5' triiodothyronine (reverse T_3 or rT_3) believed to be metabolically inactive.⁹⁻¹⁰

In response to decreased circulating thyroid hormone, thyroid releasing hormone (TRH) from the hypothalamus stimulates TSH production from the anterior pituitary gland. In a euthyroid state, the release of thyroxine into circulation will directly suppress TSH as well as the TSH response to TRH. Recent studies indicate that the thyroxine feedback does not suppress TRH secretion from the hypothalamus, but rather suppresses the TSH response to TRH. Paradoxically, there is even evidence that thyroxine may have a stimulatory effect on TRH secretion and consequently exhibiting both negative and positive feedback effects.¹¹

Overproduction of thyroxine in hyperthyroidism should suppress TSH release, while underproduction of thyroxine in primary hypothyroidism should increase TSH production.¹² TSH production may also directly be decreased in pituitary insufficiency (secondary hypothyroidism) as well as indirectly by TRH deficiency in hypothalamic disease (tertiary hypothyroidism). Hyperthyroidism results in elevated I^{131} uptakes while primary, secondary and tertiary hypothyroidism all result in low I^{131} uptakes. Exogenous iodine, as well as exogenous thyroid hormone, may spuriously lower the I^{131} uptakes. Exogenous iodine lowers the I^{131} uptake by increasing the circulating iodine blood pool. Exogenous thyroid hormone may spuriously lower the I^{131} thyroid uptakes by suppressing TSH from the anterior pituitary gland via the negative feedback mechanism. Although an elevated serum TSH is highly suspicious of primary hypo-

thyroidism, it should be noted that the TSH assay by radioimmunoassay is not reliable in the low ranges. The response of TSH to TRH may, however, be extremely beneficial in differentiating secondary from tertiary hypothyroidism. A poor serum TSH response following TRH stimulation is suggestive of pituitary insufficiency (second hypothyroidism). An exaggerated serum TSH response following TRH stimulation would be expected in both primary hypothyroidism and hypothalamic disease (tertiary hypothyroidism, Table 1).

Low I^{131} uptakes due to TSH suppression by thyroid replacement as well as low uptakes due to pituitary insufficiency should both respond to TSH stimulation. In cases of exogenous iodine, the serum TSH is usually normal and should not significantly change following TSH stimulation. Prolonged suppression of TSH by exogenous thyroid hormone may, however, transiently decrease the pituitary thyrotropin reserve for several weeks after withdrawal of thyroid hormone and result in persistent undetectable basal TSH concentrations with no significant response to TSH stimulation.¹³⁻¹⁸

Recent reports have indicated that the normal values of I^{131} thyroid uptake have been lowered by the abundance of exogenous iodine in food products, drugs and iodine containing contrast radiographic media.¹⁹⁻²³ It is therefore apparent that a low I^{131} uptake is a sensitive, but not a specific index of hypothyroidism. The T_3 and T_4 studies performed either by resin uptake or by radioimmunoassay have been recognized as reliable indices of circulating thyroid hormone. Both resin uptakes and radioimmunoassay methods rely on competitive binding principles and are available in most community hospitals.²⁴⁻³⁴ Although not significantly influenced by iodine, factors that increase TBG will decrease the T_3 resin uptake and increase the T_4 resin. Con-

versely, factors that decrease TBG will increase T₃ resin uptake and decrease T₄ by resin uptake.³⁵⁻³⁶ TBG is known to be increased by exogenous and endogenous estrogen production as well as by pregnancy and hepatitis.

TBG is conversely decreased by exogenous T₃, androgens, hypoalbuminemia, protein loss, chronic obstructive pulmonary disease, supraventricular cardiac arrhythmia and competitive binding interference by a variety of drugs (Prednisone, heparin, phenylbutazone, diphenylhydantoin, salicylates and penicillin).³⁶⁻³⁸ Although influenced by TBG, the serum T₃ and T₄ derived by radioimmunoassay procedures are true measurements of circulating T₃ and T₄ hormones.

Alteration in TBG production or competitive drug interference will result in inverse changes in the T₃ (Resin) and T₄ values derived by Resin or RIA. These discrepancies in TBG may be mathematically corrected by a factor called the T₇ (Abbott Laboratory). The T₇ (free thyroxine index) is derived by multiplying the T₃ (Resin) x T₄ (Resin or Radioimmunoassay) value and is recognized as an expression of circulating thyroxine.³⁹⁻⁴² Fortunately, exogenous

iodine does not significantly influence the T₃, T₄ or T₇ values. Therefore, in the absence of thyroiditis, a low I¹³¹ uptake but normal T₇ value, would suggest exogenous iodine interference as opposed to the low I¹³¹ uptake and low T₇ values of hypothyroidism. As has been mentioned, serum TSH values would be expected to be increased in the cases of primary hypothyroidism and normal by exogenous iodine. In acute thyroiditis, the I¹³¹ uptakes are characteristically very low with an unpredictable T₃, T₄ and T₇ and an elevated sedimentation rate. The I¹³¹ uptake as well as T₃, T₄ and T₇ are all unpredictable in chronic thyroiditis. The organification abnormality of chronic thyroiditis may be detected with the perchlorate washout maneuver. Thyroid antibodies, when present, are diagnostic of chronic thyroiditis. The T₃, T₄ and T₇ are low in hypothyroidism and elevated in hyperthyroidism.

It is, therefore, apparent that low I¹³¹ uptakes are not diagnostic of hypothyroidism and may also be the result of exogenous iodine, exogenous thyroid, or thyroiditis. We have no influence over the abundance of iodine in drugs and food products in our environment

that lower I¹³¹ uptakes. We also have no influence over the frequency of thyroiditis that may lower the I¹³¹ uptake and vary the T₃, T₄ and T₇. We can, however, influence the intelligent scheduling of thyroid iodine uptakes prior to iodine containing radiographic procedures to ultimately decrease the frequency of the low I¹³¹ normal T₇ dilemma.

Summary

In normal subjects, the radioactive iodine thyroid uptake is a reflection of the metabolic feedback homeostasis between hypothalamic (TRH) and anterior pituitary (TSH) centers responding to circulating iodine and thyroid hormone. Low I¹³¹ uptakes are not specific for hypothyroidism and may also be noted in thyroiditis as well as in TSH suppression by thyroid hormone replacement or with saturation of the iodine pool by exogenous iodine. A complete thyroid profile with T₃, T₄, T₇, TSH, thyroid antibodies as well as TRH and TSH stimulation studies are often essential in the differential diagnosis of the low I¹³¹ uptake.

The T₇ is derived by multiplying the T₃ (resin) and T₄ (resin or radioimmunoassay). This product is an acceptable expression of circulating thyroxine. Fortunately, iodine does not significantly alter the T₇ values. Therefore, in the absence of thyroiditis, a low thyroid uptake of radioactive iodine concomitantly with a normal T₇ is often the result of exogenous iodine interference.

Intelligent scheduling of thyroid uptake studies prior to performing radiographic procedures with iodine containing contrast media is imperative in avoiding "The Low Thyroid Uptake—Normal Thyroid Dilemma."

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Table 1: Differential Diagnosis of the Low Thyroid Iodine Uptake

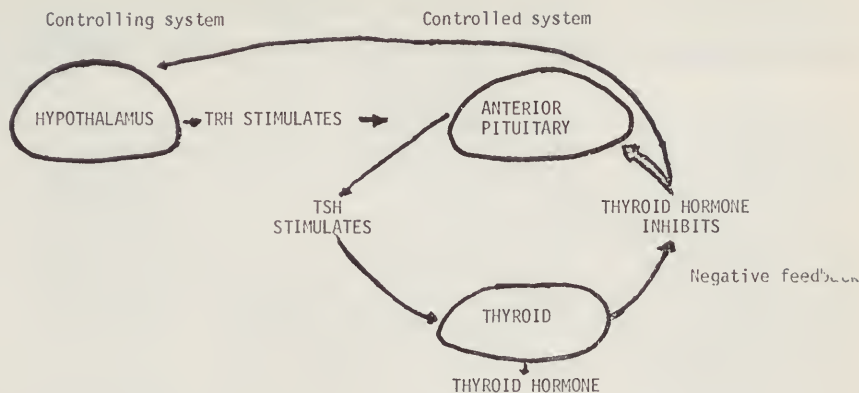
	¹³¹ I Uptake	TSH	T ₃ -T ₄ -T ₇	TRH Stimulation (TSH Response)	TSH Stimulation (¹³¹ I Uptake Response)
Primary Hypothyroidism	↓	↑	↓	R	O
Secondary Hypothyroidism	↓	↓	↓	O	R
Tertiary Hypothyroidism	↓	↓	↓	R	R
Thyroid Replacement	↓	↓	N	R	R
Exogenous Iodine	↓	N	N	R	R
↓ decrease					
↑ increase					
N normal					
R normal or exaggerated response					
O poor response					

Note: In acute thyroiditis, the I¹³¹ uptakes are very low with unpredictable T₃, T₄ and T₇. In chronic thyroiditis, the I¹³¹ uptakes as well as the T₃, T₄ T₇ values are all unpredictable.

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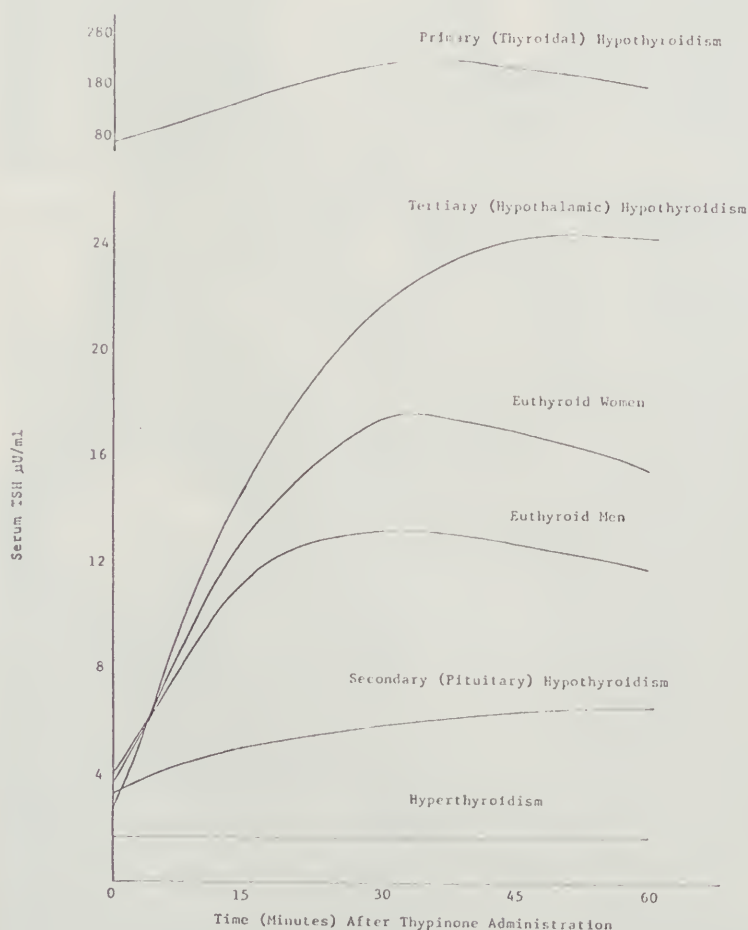
OVERVIEW OF ENDOCRINE SYSTEM



Regulation of thyroid activity.

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|---|--|

Classical Patterns of TSH Response After Thyronine *



* Thyronine - TRH (Abbott Laboratories) - Diagnostic Division - Scientific Affairs Dept.
Dr. Stephen Weiss - Abbott Laboratories.

George V. Eltgroth is a Patent Attorney for General Electric. He is legally blind.

George Eltgroth's official title is Counsel for Patent Strategy and Utilization. His work for the International Division of GE involves finding people who infringe on GE patents and handling cross licensing agreements between major corporations.

Eltgroth is 62. When he was 33, he contracted polio. It took him two years before he was able to walk with a cane. At 41 his vision dropped below the level of legal blindness. But, as Eltgroth points out, "There wasn't anyone who was going to look after me. I had four small children. I had to continue my career." In 1964, Eltgroth negotiated one quarter of GE's acquisition of Compagnie des Machines Bullé from Olivetti. He was put in

charge of patent operations in Phoenix, Milan, and Paris. "I had 20 French lawyers working for me," says Eltgroth, "only two of whom spoke English. So I learned French, not from books, but by ear." Eltgroth is also fluent in German and is able to work in Spanish as well.

"Handling forms is hard for me," says Eltgroth. "I have only peripheral vision about 1 or 2 percent of normal. I read slowly, so I have to do a lot of preparatory work for patent negotiations. My handwriting is weak, so I type. I have physical problems, but by developing my abilities in law and technology, I'm able to make the balance come out positive. I've wrapped up negotiations that would have taken most non-handicapped people five years

in two. When you're handicapped, you've got to test your limits. As a result of my polio, falling is dangerous—ice and snow are a problem. So I put screws in the bottom of my galoshes. When I had crutches, I put hooks on them for my briefcase. You shouldn't dwell on what's lost, but on what you have left."

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Simple Method for Determination of Thyroxine in Serum. *J. Clin. Endocr.* 26:99, 1966.

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Radiological

CASE OF THE MONTH

A service of the Maryland Radiological Society

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Drs. McCrea and Haney are Assistant Professors at the University of Maryland Hospital's Department of Diagnostic Radiology, 22 S. Greene St., Balto., MD 21201, where they can be contacted for reprint and other data.

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Case History

An eight-month-old black female presented to the emergency room with a three-week history of vomiting and decreased appetite. She had been seen three weeks prior to admission for similar symptoms. The patient was diagnosed as having viral gastroenteritis and a clear liquid diet was prescribed. Intermittent vomiting continued, resulting in two more visits to the emergency room. She had associated abdominal distention, decreased flatus, more frequent burping and vomiting after each feeding. Rectal temperature on admission was 101°F.

Vomiting was non-projectile, with no blood or bile. Bowel movements were decreasing in frequency, without gross blood or melena.

A plain abdominal film was obtained (Figure 1).

The abdominal radiograph (Figure 1) shows an abnormal gas pattern, with primarily small bowel loops. Some colonic gas is noted with a soft tissue mass in the mid-transverse colon outlined by intraluminal air.

What are the radiographic findings? Diagnosis? How would you manage this patient?

Answer on next page.



FIGURE 1: Plain supine abdominal radiograph.

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Radiological Case of the Month

Case history on preceeding page.

Discussion

Based on the clinical history and abdominal radiographic findings, a diagnosis of intussusception was made. This was confirmed by a barium enema (Figure 2). Partial reduction of an ileocolic intussusception was obtained; however, an irreducible ileocolic segment in the cecum was encountered (Figure 3), and the patient was taken to the surgical suite. At surgery, a portion of the terminal ileum was gangrenous, necessitating surgical removal of the gangrenous segment including the cecum with anastomosis of the remaining terminal ileum and ascending colon.

Intussusception is the most common cause of in-



FIGURE 3: Irreducible ileocolic segment in cecum.

testinal obstruction in infants and children between the ages of two months and five years,¹ with two-thirds occurring in patients below two years. Peak incidence occurs between the third and eleventh months of life. Sex incidence varies: Benson et al¹ reported a 2:1 male preponderance in their series of 300 cases, while Gierup et al² reported an absence of sex predominance in their series of 288 cases.

The etiology remains obscure in 85-90% of cases. Most authors regard the presence of prominent and/or hypertrophic lymphoid tissue in the terminal ileum of infants below one year of life as the primary mechanical factor in the production of intussusception. In addition, Margulis³ suggests that the change from a liquid to a solid diet, with subsequent increased peristaltic activity, may be an important, precipitating factor. In a small percentage of cases, an organic leading point may be found such as Meckel's diverticulum (the commonest local cause), cecal duplication, leiomyoma, intestinal polyp and lymphosarcoma.^{1-2, 4}

Some authors have reported a seasonal incidence,⁴ one peak occurring in the spring and another in the summer. The first peak corresponded with a high incidence of upper respiratory tract infections, pertussis, measles and German measles. The other peak corresponded with the peak incidence of various kinds of gastroenteritis. Other authors reported the absence of such seasonal incidence.¹

The classic triad of intermittent abdominal pain, vomiting and bloody stools is encountered in only 10-12% of cases. Either vomiting or abdominal pain is the most common presenting symptom according to different series (vomiting in 92% in the study by Freund et al and abdominal pain in 91% of cases in Gierup's study). Bloody stools occur from 16-56% and

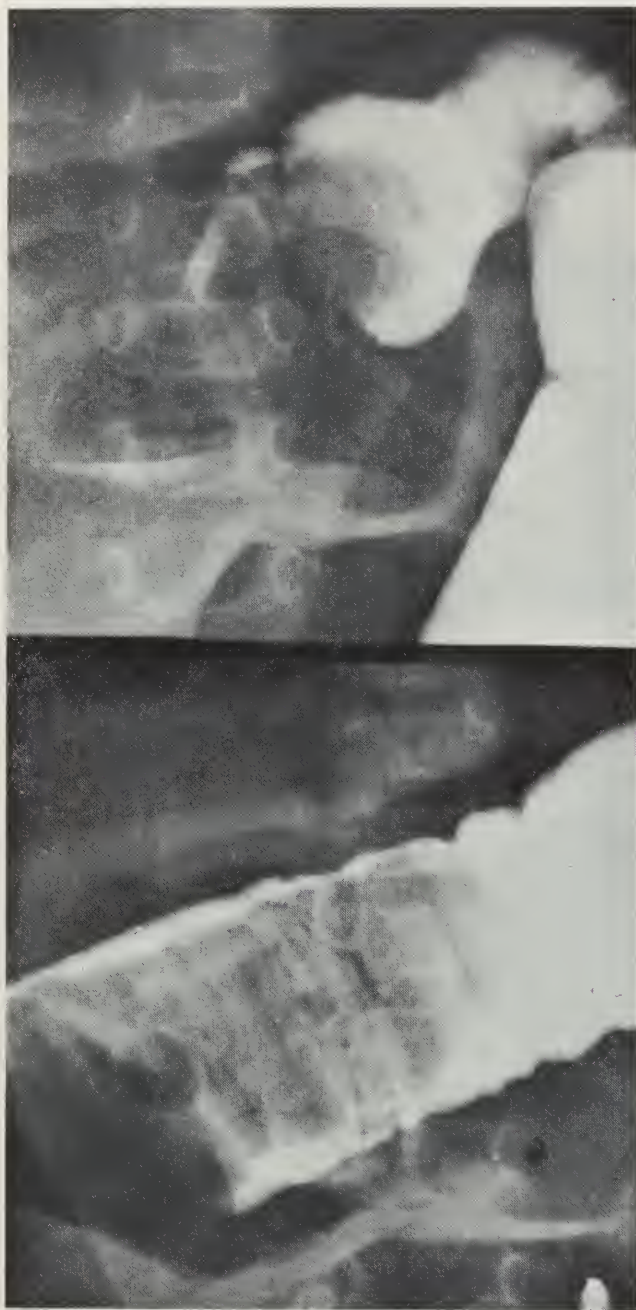


FIGURE 2: Barium enema showing progressive reduction of ileocolic intussusception.

are more common in patients less than one year of age. Other symptoms include upper respiratory tract infections, high fever, diarrhea and constipation.² A palpable abdominal mass was found in 24-56% of patients.

Roentgen signs are variable. The definitive finding would be a visible abdominal mass on a plain film with verification by barium enema. The apex of the intussusception, the intussuscepiens, can be seen outlined by intraluminal air (as in our case) in only 15% of patients. Other signs include an abnormal gas pattern and intestinal obstruction. Often, the abdominal radiograph is normal, and if the clinical index of suspicion is high, a diagnostic barium enema should be performed.

The barium enema can be used primarily as a diagnostic tool,¹ with surgery the definitive corrective procedure, or it can be used as the primary therapeutic procedure for reduction, with hydrostatic pressure resulting in 81% success in Gierup's series. The enema bag is placed at 150 cm. above the table with one-three attempts at successful reduction. Success rates vary according to the number and severity of symptoms, duration of illness and kind of intussusception.² Freund et al reported successful reduction by enema in 47% of all patients, with 86% of this achieved in patients symptomatic for less than 24 hours. Gierup et al reported an overall success rate in 81-87%, with patients subjected to surgery only after failure of enema reduction. Benson's group preferred the use of the enema primarily as a diagnostic tool at their institution (Children's Hospital of Michigan). Recurrence rate following enema reduction was 6-10%; that following surgical reduction 3.9%.¹

Surgical procedures depend on surgical findings. Bowel resection was done for irreducible intussusception or the presence of gangrenous bowel or lead points such as Meckel's diverticulum. Manual reduction for edematous bowel may also be done at surgery.

Summary

In summary, intussusception is the most common cause of intestinal obstruction in infant and children, with a peak incidence between 3-11 months of life. Presenting symptoms are vomiting and abdominal pain and discomfort. Radiographic findings may include a visible mass, an abnormal gas pattern, intestinal obstruction or an essentially normal abdomen. Clinical suspicion of intussusception warrants a barium enema, either for diagnosis alone or for therapeutic reduction.

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4. Etiologic and Therapeutic Aspects of Intussusception in Childhood, H. Freund, H. Hurvitz and M. Schiller, Amer. J. Surg. Vol. 134, pp. 272-274, August, 1977.

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Doctors in the News

Dr. Maddrey Named Associate Physician-in-Chief

Willis C. Maddrey, MD, has been named Associate Physician-in-Chief of the Johns Hopkins Hospital and Associate Director of the Department of Medicine of the Johns Hopkins School of Medicine. Dr. Victor A. McKusick, Physician-in-Chief and Director of the Department of Medicine, announced recently that Dr. Maddrey would assume the newly-created positions.

Dr. Maddrey will be responsible for faculty and housestaff development in the Department of Medicine, the largest department at Hopkins, with a total of 400 full-time and part-time physicians and 85 housestaff members.

Since 1975, Dr. Maddrey has been Assistant Dean for Postdoctoral Education and Faculty Development at the Hopkins School of Medicine. In that position, he has developed teaching affiliations for Hopkins medical students and housestaff at surrounding hospitals.

An Associate Professor of Medicine, Dr. Maddrey will also continue to direct the Hopkins Liver Disease Program. His research in liver disease has recently centered on the treatment of acutely-ill patients with alcoholic hepatitis and the complications of cirrhosis.



DR. MADDREY

A Fellow of the American College of Physicians, Dr. Maddrey is an Associate Editor of *Medicine* and on the Board of Consulting Editors of the *American Journal of Medicine*. He is also on the gastroenterology board of the American Board of Internal Medicine, the governing board of the American Association for the Study of Liver Disease and the national board of directors of the American Liver Foundation.

A graduate of Wake Forest University, Dr. Maddrey received his Medical Degree at the Johns Hopkins School of Medicine, where he was named a member of the Alpha Omega Alpha Honorary Society. He completed his housestaff training at Hopkins, serving as Chief Resident on the Osler Medical Service from 1969-70.

He did postgraduate work on liver disease at Yale University and conducted research on liver disease in India with the US Public Health Service. □

Dr. Bormel Elected President

Paul Bormel, MD, a native of East Baltimore and a member of the St. Agnes Hospital medical staff, has been elected as President of the Board of Directors of the Baltimore City Medical Society Foundation, Inc.

The Foundation is the philanthropic arm of the BCMS and coordinates and distributes contributions donated on behalf of the Society and its members for useful, worthwhile endeavors.

Recent activities include presentation of several sizable scholarships to Baltimore residents who may be encountering financial difficulty during medical school training, with the hope that they will return to practice in the local community.

The Board members also include Ronald Fishbein, MD; Misbah Khan, MD; Anne McKusick, MD; Nathan Needle, MD; Roland Smoot, MD and Karl Weaver, MD. □

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

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The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age, known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL. Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication, abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE. To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE. Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

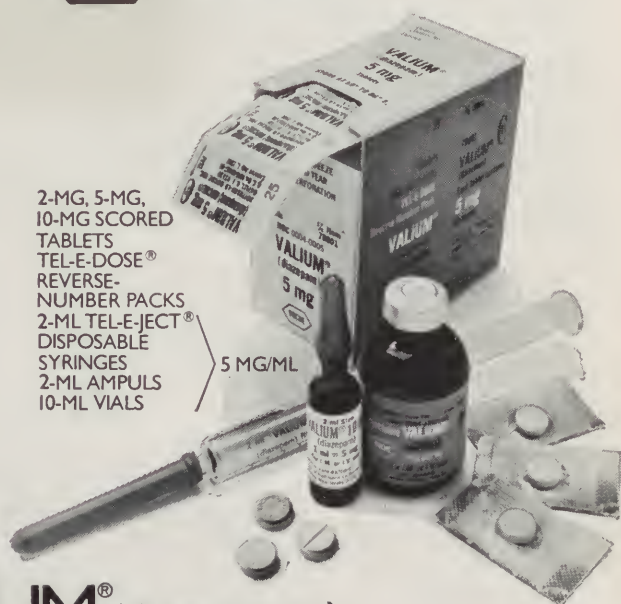
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levetterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

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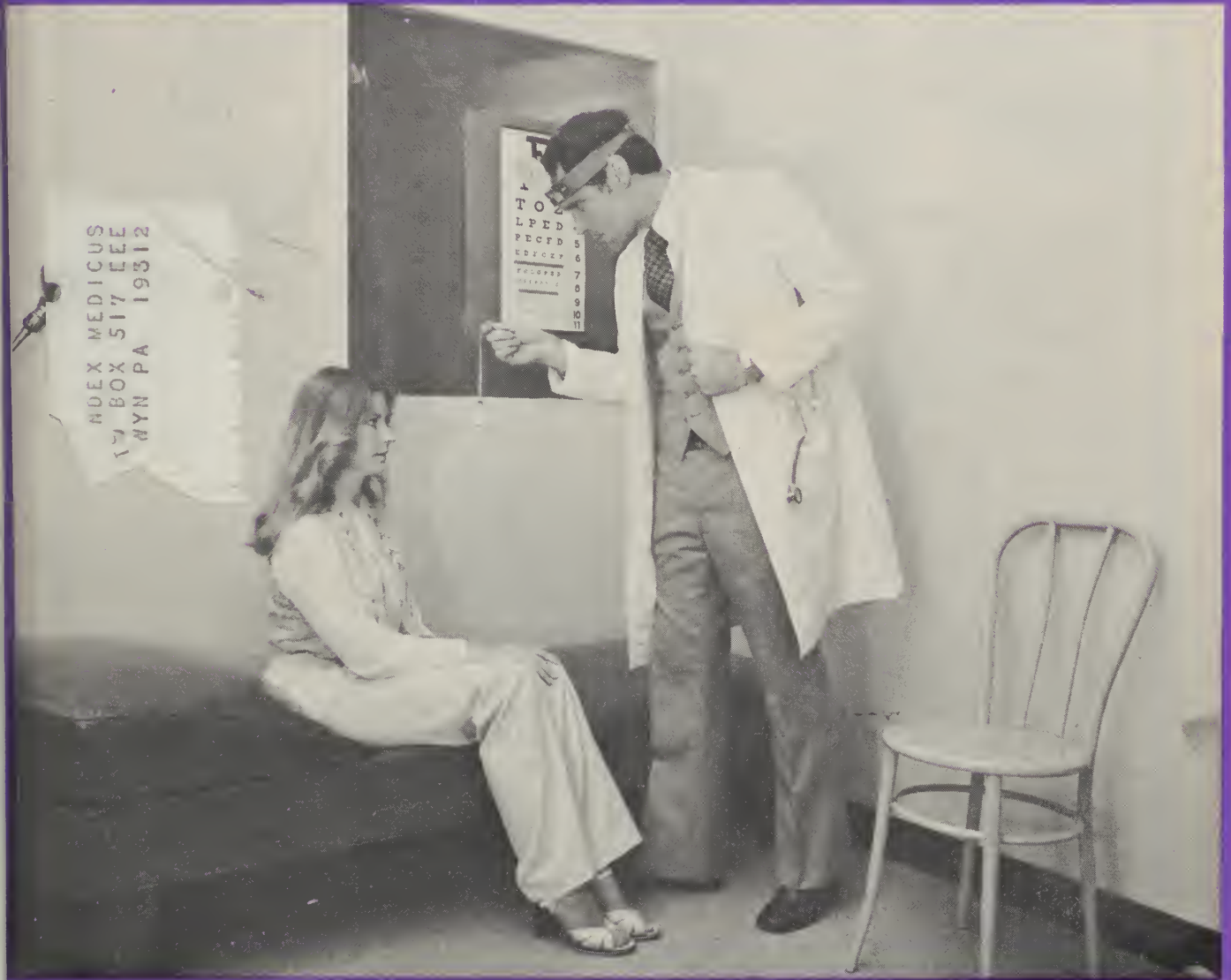
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JULY 1979

MARYLAND STATE MEDICAL



Journal



MEDICAL HYPNOSIS VERSUS HYPNOTISM:
WHAT THEY ARE - AND WHAT THEY ARE NOT

An Exclusive Interview With Edward O. Hunt, Jr., MD

... page 35

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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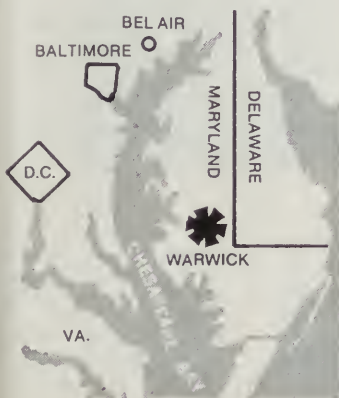
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MARYLAND STATE MEDICAL Journal

Volume 28

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Number 7

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EDITORIAL and BUSINESS OFFICE:
11 Cathedral St., Baltimore, MD
201. Phone 1 (301) 539-0872.
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Medical and Chirurgical Faculty
of the State of Maryland. Second



Class postage paid at Baltimore, MD.
Accepted at the special rate au-
thorized. Published monthly.
Subscription rates: US, US Pos-
sessions, one year \$8; elsewhere
\$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily
reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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MEDICAL HYPNOSIS IS NOT DONE THIS WAY, says Dr. Edward O. Hunt, Jr. in an exclusive interview beginning on p. 35 in this issue.

This month's cover model is Janice Harms, 20, of Carney, MD, who attends Essex Community College.

(Claude Brooks Photography.)

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Your Medical Faculty At Work

JOHN SARGEANT, CAE, Executive Director

Council

The Council met on May 2, 1979, just prior to the annual session of the House of Delegates. The meeting was held at Hunt Valley Inn, Hunt Valley, MD.

The Council took the following actions:

1. Heard from representatives of the Maryland High Blood Pressure Commission and understood from these persons that it was not the intention of the Commission to endorse a pharmacist to "evaluate, diagnose and treat where there is both a patient need and available and qualified pharmacy personnel."

Determined that a communication be directed along these lines to the appropriate persons, and also request a correction be carried in the next issue of the **Maryland High Blood Pressure Council News**.

2. Recommended, on component society requests, the granting of Emeritus Membership to certain physicians.

3. Requested the **Journal** Editorial Board to publish an obituary on I. Ridgeway Trimble, MD of Baltimore.

4. Waived 1979 dues at the request of a component for a physician who is ill.

5. Increased mileage allowance for automobile travel for Faculty officers, staff and committee members when travelling on Faculty business to \$.20 per mile effective June 1, 1979.

The Council met on May 5, 1979, immediately following adjournment of the House of Delegates and took the following actions:

1. Elected Albert M. Antlitz, MD, Baltimore, as Council Chairman.

2. Elected J. Roy Guyther, MD, Mechanicsville, as Council Vice Chairman.

House of Delegates

The House of Delegates met on May 2, 1979, at Hunt Valley Inn, Hunt Valley, MD and took the following actions:

1. Heard from Charles Buck, DSc, newly-appointed Secretary of the Department of Health and Mental Hygiene.

2. Heard an annual report from the President which will be printed in full in the Annual Report issue of the **Journal** in August, 1979.

3. Heard from Daniel Cloud, MD, of Phoenix, AZ, who is Secretary-Treasurer of the AMA and a member of the Board of Trustees.

4. Heard from visiting State Society Presidents.

5. Observed a moment's silence for deceased members.

6. Adopted several Memorial Resolutions of former members.

7. Presented 50-Year Certificates and Pins to those members earning this accolade.

8. Granted Emeritus Membership to physicians who had received the recommendation of their Component Society and the Council.

9. Adopted several bylaw amendments.

10. Instructed the Bylaws Committee to develop another bylaw amendment regarding the Legislative Committee.

11. Received the Nominating Committee report.

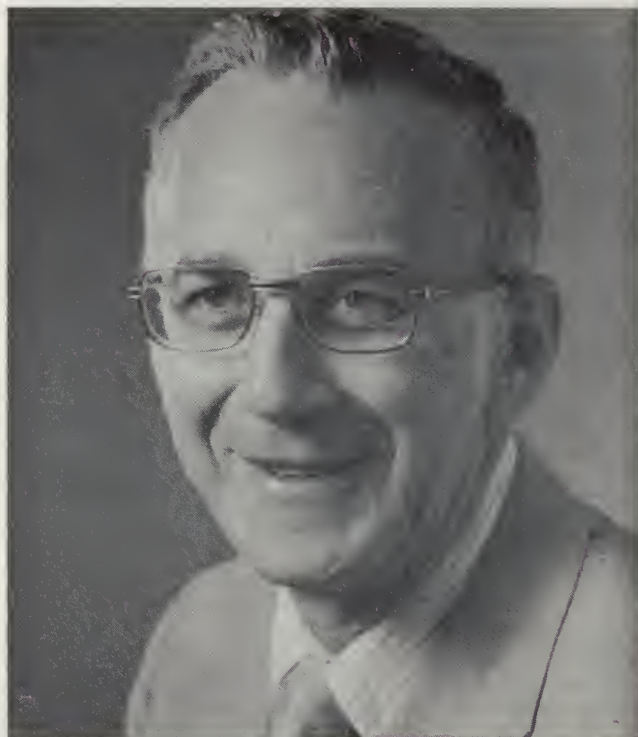
The House met in its second session on May 5, 1979, again at Hunt Valley Inn, Hunt Valley, MD, and took the following actions:

1. Heard the election of Board of Medical Examiners members who were elected at the General Meeting on May 3, 1979.

2. By unanimous consent, dispensed with the ballot and elected all nominees submitted to the House on May 2, 1979.

3. Heard reports from Richard F. Moschell, MD, Chairman of the Maryland Medical Political Action Committee, and from Mrs. Kassie Herbert, Auxiliary President. Both reports will be contained in the annual report issue of the **Journal** in August, 1979.

4. Adopted a resolution dealing with the disease of alcoholism and urged various groups to contain basic insurance benefits for this disease in their health insurance policies. □



DR. ANTLITZ, New Council Chairman.

(Photo by Tadder, Balto.)

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The Open Forum

"One-Sided Exposition . . ."

To the Editor:

I was distressed to receive my April, 1979 issue of the *Journal* because of the one-sided exposition of the advantages of belonging to the AMA. (Ed. note: **Should Med-Chi Members Also Be AMA Members? Interviews With Drs. Russell Fisher, Charles O'Donnell and Stephen Padussis to Help You Decide - - - BT.**)

The title page, in fact the frontispiece, of the *Journal* says Should Med-Chi members also be AMA members? but, in fact, on the inside there are three articles all unreservedly in favor of such action. It's not clear from the introduction to these three obviously-slanted pieces as to whether or not opponents belonging to the AMA were ever consulted as to the opportunity of rebuttal. Since when is an issue resolved without having two opposing sides state their cases?

Although this letter is meant only as a complaint about the lack of opposition views being printed in the *Journal*, I would have to point out that there are several issues raised by the three distinguished physician of the Faculty which require addressing. Number one, the implication is clearly stated, especially in Dr. Fisher's comments, that the only opposition to AMA membership comes from left-wing, radical, academic, university-based physicians. This is just absolutely not true. Furthermore, there is an element of *argumentum ad hominem* in Dr. Fisher's article about physicians with academic appointments that vitiates his argument.

The second point I'd like to make is the very fact that the youngest member in the Faculty to be an AMA Delegate of the three is 56 years old is exactly one of the reasons that the younger physicians do not want to join. Someone who has perhaps five or 10 years remaining of productive practice can hardly be considered representative of the younger physician, and I'm not speaking of the house officer now, I'm speaking of the physician in the age-range from 35-45.

It is not my intention to write a rebuttal to these distinguished physicians, as my opposition to membership in the AMA is well-known, but I do think that when an issue like this is to be aired in our *Journal*, that both sides should have opportunity to state their cases.

Thank you again for your consideration.

PARK W. ESPENSHADE, JR., MD

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The Physician Assistant

To the Editor:

Physician Extenders were originated some 15 years ago at Duke University in North Carolina. The intention was to provide professionals to help fill the gap in the envisioned physician shortage. These new health workers were trained to extend the capabilities of the physician by performing many of the duties that were traditionally "physician-only."

Many of the original Physician Extenders were accepted to the field by virtue of past experience: the grandfather clause. Now, due to the increasing demand to possess more sophisticated medical knowledge, Physician Extenders must graduate from an American Medical Association-approved Physician Assistant Program. After completion of training, they must sit for a national certifying examination.

As the role of the Physician Extender has evolved, a myriad of titles for the profession has emerged. Some of the names these individuals will answer to include "Physician Assistant," "Physician Associate," "Health Associate," "Clinical Associate," "Medex" and "Health Practitioner." The American Academy of Physician Assistants, however, encourages the use of the term "Physician Assistant."

All this may appear, at first, to be an exercise in semantics. I feel, though, the decision to adopt the title, "Physician Assistant" (PA) by our professional academy should speak of the light in which the PA sees himself. PAs are trained individuals who desire to work with a physician to obtain the goal of quality health care. As the title implies, the PA is an assistant to the doctor. He is not out to replace the doctor, nor does he have the ability. It is true that the Physician Assistant can perform many of the functions that were traditionally the physician's role. Often times these functions can be accomplished with more expertise by the PA. The Physician Assistant can, in a variety of settings, make independent decisions and implement therapy. The PA, however, is limited in his scope of knowledge and abilities. Any Physician Assistant who does not recognize this is only disillusioning himself. This should not, however, mean that PAs are "second-rate" practitioners. PAs are good at what they do. All they need is a chance.

PAs do not want independent practice. They want and need the supervision of the physician. This supervision, however, may come in many forms. For some clinical settings, the Physician Assistant needs direct supervision. An example of this would be the case of a PA first assisting in surgery. Other settings would lend themselves to more relaxed supervision. A PA following a group of hypertensives could function with protocols, frequent chart reviews and consultations as required. The Maryland State Board of Medical Examiners at this time tends to be conservative in its definition of supervision. The practicing community of PAs asks for the opportunity to prove themselves and help the physician provide quality health care in an unencumbered way.

The National Certifying Examination for Physician

Assistants provides a standard by which to measure PAs' acumen. This tool should be used to assure the quality of practicing PAs. Prospective employers of Physician Assistants should demand certification, and the Board of Medical Examiners should likewise require certification for registration.

The Physician Assistant sees himself as a valuable member of the medical team. We want the chance to work with the physician in an ever-expanding role to provide service to the patients.

GERALD K. WALTERS, PAC
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Medical Miscellany

Hopkins Allergists Hope to Determine Which Children Endangered by Insect Stings

Will a child who has suffered from hives, swelling of the face, hands and feet or all-over itchiness after being stung by an insect have a more serious or even life-threatening allergic reaction if stung again?

Most doctors and parents fear the answer is yes, and many shelter such children from outdoor activity, but Johns Hopkins allergists at Good Samaritan Hospital in Baltimore believe the question is far from answered and plan a large-scale study to determine which children are endangered by future insect stings and which will lose their sensitivity to stings over time.

The allergy team is looking for youngsters between 3-16 years of age who have experienced allergic reactions to insect stings to participate in the study. Children will receive a free evaluation of their sting sensitivity to determine whether and to which insect they might react if stung again. Free treatment with an effective new therapy developed by Hopkins allergists will be offered to certain participants in the study, alongwith follow-up examinations and consultations with the participants' physicians.

Parents and doctors who would like to refer a child to the study should call the Allergic Disease Center at (301) 323-2200, ex. 394.

The study is prompted by the expectation that a highly-effective, new treatment for insect sting allergies developed by Hopkins allergists will soon become commercially-available. The treatment, a series of injections of gradually-increasing amounts of pure insect venom, has prevented subsequent allergic reactions to stings in 95% of children and adults treated so far.

Though effective, the treatment will be expensive and may need to be continued for many years, perhaps for life.

These considerations raise questions about who should get the treatment. Scientists still don't know whether a person who had an allergic reaction in the past will have a worse, similar or milder reaction if stung again. Many children lose their sensitivity to stings over time, and some get more severe reactions with each sting. Those children who would lose their sensitivity quickly might not need venom therapy.

"We hope to determine who can benefit from the new insect therapy and avoid unnecessary and long-term treatment for others," says Kenneth C. Schuberth, MD, Coordinator of the study.

There are three types of reactions to insect stings, according to Dr. Schuberth: "Most people, when stung by a yellow jacket, honeybee, hornet or wasp, will have a 'normal' reaction consisting of pain and swelling at the site of the sting, lasting less than 24 hours," he says. "A small number of people will have a 'non-life-threatening generalized reaction' to the sting. They may itch all over, break out in hives and swell on the face and the extremities. Most serious is the 'life-threatening generalized reaction,' which is accompanied by difficulty in breathing, a drop in blood pressure, unconsciousness and, rarely, death."

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CONRAD ACTON, MD, Editor

May Meeting

Sufficiently-removed from the Med-Chi Meeting to provide some perspective, the May BCMS meeting only briefly reviewed the actions taken there. President Antlitz reported that the Bylaws amendments were approved as printed in the *NEWS-LETTER*.

President Antlitz, for the first time, presented Membership Certificates to all newly-elected members present to receive them: Drs. Butta, Garcia, Kaminsky, Scott and Knauer. Any other members who would like a Certificate of Membership should inform the Society Office and one will be prepared for them.

Edmund Beacham, MD, Chairman of Tellers, announced the results of our run-off election. William G. Helfrich, MD, is our third, newly-elected Representative on the Med-Chi Council.

Dr. Heldrich Speaks

Fred Heldrich, MD, Chairman of the Professional Education Committee and also Chairman of the Department of Pediatrics at St. Agnes Hospital in Baltimore, assumed the gavel for the scientific portion of the Meeting. He doubled in brass by starting right in to present the evening's topic: *Educators and Physicians: Partners in Child Health*. The physician's responsibility to the partnership, he said, is three-fold: to *evaluate* the child to *treat* any treatable conditions and to *monitor* the results of treatment. This is a continuing, progressive responsibility through all the school years. Three periods emerge where change is most likely to happen and medical alertness is most needed. First, is on entrance to the school program when everything is new to the child and the child, in turn, is most malleable.

Second, is at the third to fourth grades where reading begins and understanding the printed word is so important. Third, is in about the seventh grade when adolescence insidiously begins to take hold.

Dr. Crew Talks

A splendid slide show and commentary on the Baltimore school system introduced Dr. John L. Crew, Sr., Superintendent of Public Instruction in the Baltimore City Public Schools. Noting that truancy had plagued Baltimore schools in the preceding decades to the extent that 25-30% of the students might be absent on any one day, he described plans made to combat truancy. Special schools were made the major thrust in regeneration of the school system. Dr. Crew interpreted many graphs and provided some more current statistics. He discussed questions of discipline and possible language curriculum, i.e., Latin. Most of the system's present problems, he declared, stem from financial causes. It boils down to the balance of salary versus staffing. The educator's contribution to the partnership should be along four thrusts, also: Health Considerations Planning, Health Education, Health Services to students and Health Staffing improvements and availability of consultation to the Health Staff when needed.

Directors Meet

The Directors had a long agenda when they met May 15th, starting with consideration of the resignation of two members of the recently-formed Mayor's Medical Advisory Committee to the Fire Department. The discussion centered around appropriate specialty representation, particularly alcoholism. New designees will be intended to broaden the interests represented by the members chosen.

The 10 major causes of death in Baltimore were the subject of the Public Education Committee's communication from Earlie

H. Francis, MD, its Chairman. It's recommended that the BCMS initiate some effort to make the public more aware of them and what can be done about their prevention, possibly some presentation through investigative reporting and cooperation of one or more physicians recognized as an expert on one or more of the causes.

Also suggested was revival of the *Day with a Doctor* project of a few years back. This would be an educational program for high school students considering careers in the health fields. Development of both projects was authorized.

The Public Relations Committee will be supported in two outreach efforts, a June, 1979 participation in the American Indian Study Center's Health Fair in Fell's Point and a September, 1979 exhibit in the Baltimore City Fair. The City Fair will center on the twin topics of *Cost Containment of Medical Services* and *Alcoholism*. The American Council on Alcoholism, with the State and City Police Departments, will participate. There will be exhibit panels and breathalyzer tests. An estimate for an exhibit on *Cost Containment* from the Hopkins Medical Art Department will be sought.

The Directors also approved in principle support for a November, 1979 Physical Fitness Fair for Women proposed by the Public Health Committee, Vincent Fitzpatrick, MD, Chairman. Other sponsors would be the Mayor's Office, the Health Department and the American College of Ob-Gyn.

Dr. Yaffe's Talk

Among proposals from the Finance Committee, Kennard L. Yaffe, MD, Chairman, is a review of our Society's election process. It is the more costly because of the tear-off envelope used to ensure the privacy of the vote. The Bylaws Committee was directed to investigate less expensive secret ballot methods.

Elliott R. Fischel, MD, Chairman of the Peer Review Committee, reports problems with the Blue Shield Profile system. From experience with physicians brought before it who are in conflict with the system, the Committee deems the Profile System to be inflationary, grossly unfair and susceptible to gross abuses. This problem was referred to the Committee on Third-Party Carriers for consideration and possible resolution. □

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Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL.

IN THE MATTER OF EMMETT DAVIS, MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

By letter dated June 7, 1978, John E. Adams, MD, Chairman of the Commission on Medical Discipline of Maryland, advised Emmett Davis, MD (the "Respondent") through his attorney, Alfred L. Scanlan, Jr., that a hearing would be held on June 20, 1978 to consider whether the Respondent had violated certain conditions set forth in the Commission's Feb. 21, 1978 Order upon which he was placed on probation and the revocation of his medical license stayed. The conditions in question are as follows:

"3. That the Respondent undertake a minimum of five hours per week of Continuing Medical Education as approved by the Commission.

4. That the Respondent undertake a preceptorship program at his expense, such program to consist of at least eight hours per week with the preceptor and the plan of preceptorship to be approved by the Commission.

6. That the Respondent shall submit to continuing quarterly review of his practice by the Peer Review Committee of the Medical and Chirurgical Faculty of Maryland.

7. That the Respondent shall have the preceptor and the Peer Review Committee submit quarterly reports evaluating the Respondent's improvement. Should such quarterly reports indicate that the Respondent's medical skills are not improving, the Commission may, at its option, conduct a hearing to consider the withdrawal of the Stay based on Respondent's failure to improve his medical skills."

The hearing was convened at 4 PM before John E. Adams, MD; John G. Ball, MD; Jerome J. Collier, MD; Eli M. Lippman, MD; Karl F. Mech, MD; William A. Pillsbury, MD and Frank M. Shipley, MD, constituting a quorum of the Commission. The Respondent appeared with his attorney, Alfred L. Scanlan, Jr. Stephen J. Sfekas, Assistant Attorney General, presented the case on behalf of the Commission. Jack C. Tranter, Assistant Attorney General, advised the Commission on rules of evidence. The hearing commenced with Mr. Sfekas presenting a Stipulation of Facts agreed to by both parties. He then rested the Commission's case. Mr. Scanlan then called the Respondent to testify on his own behalf. The following documentary evidence was also produced:

Respondent's Exhibit #1—Letter dated Apr. 7, 1978, from Joseph I. Berman, MD, Chairman, Peer Review Committee, Medical and Chirurgical Faculty, to Emmett P. Davis, MD.

Respondent's Exhibit #2—Copy of a letter dated Apr. 14, 1978, from Alfred L. Scanlan, Jr., Esq. to Jack C. Tranter, Esq.

Respondent's Exhibit #3—Copy of a letter dated May 1, 1978, from Alfred L. Scanlan, Jr., Esq. to Joseph I. Berman, MD.

Respondent's Exhibit #4—Copy of a letter dated June 12, 1978, from Alfred Scanlan, Jr., Esq. to Jack C. Tranter, Esq.

Respondent's Exhibit #5—Copy of a letter dated Apr. 24, 1978 from John E. Adams, MD to Edward J. Kowalewski, MD with writing in pen at the bottom.

Following closing arguments, the hearing was concluded.

Further information was submitted to the Commission by Mr. Scanlan in letters dated June 22, 1978 and July 13, 1978.

Findings of Fact

Based on the testimony and documentary evidence produced, the Commission made the following findings of fact:

1. That on Feb. 21, 1978, the Consent Order between the Respondent and the Commission was finalized. A copy of the Commission's Feb. 21, 1978 Order is attached hereto and made a part hereof.

2. That on Apr. 1, 1978, the Respondent left the private practice of medicine and began employment with the US Army as a civilian physician.

3. That the Respondent's medical services for the Army presently are performed at the Edgewood Arsenal.

4. That the Respondent is the only physician at Edgewood Arsenal and his duties include:

a) Implementation of OSHA requirements;

b) Dispensing drugs;

c) Responsibility for sick-call for military personnel during which individuals are seen by non-physician military medical personnel, with the Respondent acting as their supervisor;

d) Responsibility for work-related injuries sustained by civilian employees at Edgewood Arsenal;

e) Responsibility for examining persons previously injured to determine whether they are well enough to return to work.

5. That the Commission did not receive formal notice of the Apr. 1, 1978 change in Respondent's employment and practice status until the receipt of a letter on June 12, 1978 from the Respondent's attorney to Jack C. Tranter, Assistant Attorney General, the Commission's attorney.

6. That on Apr. 7, 1978, Joseph I. Berman, MD, Chairman, Peer Review Committee of the Medical and Chirurgical Faculty, asked the Respondent for the name of his preceptor and sought to schedule the quarterly review of the Respondent's practice mandated by the Commission's Feb. 21, 1978 Order.

7. That by letter dated Apr. 14, 1978 from Alfred L. Scanlan, Jr., the Respondent's attorney, to Jack C. Tranter, Assistant Attorney General, Mr. Scanlan asked certain general questions regarding whether a change in the nature of Respondent's practice including a cessation of private practice would have an impact on the terms of the Commission's Feb. 21, 1978 Order.

8. That by letter dated Apr. 24, 1978, from John E. Adams, MD, Chairman of the Commission, to Edward J. Kowalewski, MD, with a copy to the Respondent, Dr. Kowalewski and the Respondent were advised that the preceptorship established for the Respondent at the Family Practice Program of the University of Maryland School of Medicine had been approved by the Commission.

9. That subsequent to his receipt of the Commission's Apr. 24, 1978 letter, the Respondent advised Dr. Muncy of the Family Practice Program of the University of Maryland School of Medicine that he had decided not to participate in this preceptorship program and that he was going to "pursue other options."

10. That by letter dated May 1, 1978, Mr. Scanlan asked Dr. Berman to confer with the Commission and Mr. Tranter regarding a substantial alteration of the Respondent's probation and preceptorship.

11. That by letter dated June 7, 1978, the Respondent, through his attorney, was advised of a hearing scheduled for June 20, 1978 to consider whether the Respondent had violated the Conditions of his Probation.

12. That the Respondent's preceptorship was established and was approved by the Commission on or about Apr. 24, 1978, but the Respondent unilaterally chose not to participate in that program.

13. That since Feb. 21, 1978, to the present, the Commission has not received any request from the Respondent for approval of Continuing Medical Education courses or programs he desired to take.

14. That pursuant to the Stipulation of Facts, the Respondent during the 10-week period prior to the date of the hearing, obtained 55 hours of training.

15. That all 55 hours of training were part of Respondent's orientation for his new position.

16. That none of the courses which comprised the 55 hours of training was submitted to the Commission for approval as is required by Condition #3 of the Feb. 21, 1978 Order.

17. That though none of the 55 hours of training was submitted to the Commission for approval, had it been submitted,

little of this training would have been approved as continuing medical education since Respondent continues to practice general medicine and none of this training was in that field.

18. That pursuant to Condition #3 of the Feb. 21, 1978 Order, the Respondent should have obtained 85 hours (17 weeks x 5 hours/week) of Commission-approved continuing medical education.

19. That Respondent failed to obtain any continuing medical education approved by the Commission as is required by the Feb. 21, 1978 Order.

20. That under the terms of the February 21, 1978 Order, on or before May 21, 1978, Respondent should have submitted his practice, whatever its nature, to review by the Peer Review Committee of the Medical and Chirurgical Faculty.

21. That the Respondent failed to submit his practice to review by the Peer Review Committee.

22. That no quarterly report has ever been received by the Commission from the Peer Review Committee since the Respondent failed to submit his practice to review.

23. That no quarterly report has ever been received from the Respondent's preceptor since he chose not to participate in the preceptorship program approved by the Commission and because even if he had chosen to participate in this program, no report would have been required prior to July 24, 1978 since the program was not established and approved until Apr. 24, 1978.

Conclusions of Law

Upon the foregoing Findings of Fact, the Commission makes the following conclusions of law:

1. That Respondent failed to undertake a minimum of five hours per week of Commission-approved continuing medical education in violation of the requirement of Condition #3 of the Feb. 21, 1978 Order.

2. That the Respondent unilaterally chose not to participate in the preceptorship program approved by the Commission in violation of Condition #4 of the Feb. 21, 1978 Order.

3. That the Respondent unilaterally and without the Commission's approval chose not to submit either his private or military medical practice to review by the Peer Review Committee of the Medical and Chirurgical Faculty in violation of Condition #6 of the Feb. 21, 1978 Order.

4. That because the Respondent failed to submit his medical practice to review by the Peer Review Committee no report was received by the Commission from the Peer Review Committee in violation of the requirements of Condition #7 of the Feb. 21, 1978 Order.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of July, 1978, by the unanimous vote of those members of the Commission hearing this case,

ORDERED that based on violation of Conditions #3, #4, #6 and #7 set forth in the Commission's Feb. 21, 1978 Order, the Respondent's probationary status is terminated and the Stay of the Revocation of his license to practice medicine and surgery in the State of Maryland is hereby withdrawn so that as of the date of this Order the Respondent's medical license is REVOKED; and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with Article 43, Section 130(m) of the Annotated Code of Maryland.

JOHN E. ADAMS, MD
Chairman

Discipline
Commission
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monthly in
the JOURNAL.

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IN THE MATTER OF CORAL GORDON, MD, BEFORE THE COMMISSION ON MEDICAL DISCIPLINE, FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Upon certain information coming to its attention pursuant to the provisions of Article 43, Section 130 of the Annotated Code of Maryland, the Peer Review Committee of the Baltimore City Medical Association initiated an investigation into the medical practice of the Respondent, Coral Gordon, MD. Thereafter, the Commission on Medical Discipline of Maryland, after considering the report and recommendation submitted by the Peer Review Committee, determined to charge the Respondent with certain violations of the Code. The violations charged involved the following subsection of Article 43, Section 130 (h):

(18) Professional incompetence.

Appropriate notice of the charges and the grounds from which they arose was given to the Respondent and a hearing on said charges was scheduled to be held on Nov. 21, 1978. Prior to the convening of that hearing, the Commission entered into discussion with Donald Barrick, Esq., the Respondent's counsel with regard to the charges. Following discussions between Mr. Barrick and Stephen J. Sfekas, Assistant Attorney General, counsel for the Commission, the Respondent agreed to enter into the following Consent Order. The Respondent does not admit that she has violated any of the provisions of Article 43, Section 130 of the Annotated Code of Maryland, but she acknowledges the validity of this Order in order to avoid the expense and unpleasantness resulting from these proceedings.

Findings of Fact

The Commission finds:

1. That the Respondent's medical records are inadequate.

2. That the obstetrical treatment Respondent renders in her performance of home births does not meet acceptable standards. The Commission makes no finding concerning the quality of Respondent's hospital practice. Furthermore, the Commission makes no finding as to the general question of whether a physician should perform home deliveries.

3. That the care rendered by Respondent to Joan Poehlman was unacceptably.

4. That the Respondent has made a significant improvement in the quality of her record-keeping since the beginning of the investigation of her case.

Conclusions of Law

Based upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the charge of professional incompetence has been substantiated and that Respondent is GUILTY of that charge.

Order

From the foregoing Findings of Fact and Conclusions of Law, it is this 21st day of November, 1978, by the unanimous vote of eight members of Commission of Medical Discipline

ORDERED that the license to practice medicine and surgery heretofore issued to Respondent by Board of Medical Examiners is hereby suspended, and be it further

ORDERED that the said suspension is stayed with Respondent placed on probation subject to the following terms and conditions:

1. That the Respondent shall submit to continuing quarterly review of her practice by the Peer Review Committee of the Baltimore City Medical Association.

2. That the reports submitted to the Commission by the Peer Review Committee shall indicate that Respondent is practicing medicine in a competent fashion.

3. That Respondent shall engage in not less than 100 hours per year of Continuing Medical Education, for the duration of the probation. All of the continuing education shall qualify as category 1 credit as defined by the American Medical Association.

4. That the Chief of Obstetrics at any hospital at which the Respondent delivers babies must review each patient's condition and records. The Respondent will furnish the Commission with a satisfactory quarterly report from the Chief of Obstetrics as to the quality of her hospital practice. The Chief of Obstetrics

may delegate this function to a physician acceptable to the Commission.

5. That after Jan. 1, 1979, the Respondent shall not perform any deliveries in any location other than a hospital delivery room except in emergency situations. If Respondent should perform any deliveries outside of a hospital because of emergency, she shall promptly notify the Commission in writing of the circumstances.

6. That the Respondent shall not supervise the performance of home births by or collaborate with nurse-midwives or by any other person and be it further

ORDERED that if the Respondent violates any of the foregoing conditions, upon notification by and following a hearing, the Commission may lift the stay of suspension or impose whatever disciplinary sanction it deems appropriate upon any such showing; and be it further

ORDERED that if Respondent has complied with the terms of this Order to the satisfaction of the Commission for a period of three years from the effective date of this Order, the probation shall be lifted and shall be of no further effect and be it further

ORDERED that one year after the date of this Order, the Commission will entertain a petition to terminate the Respondent's probationary status; and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners of Maryland in accordance with Article 43, Section 130(m) of the Annotated Code of Maryland.

JOHN E. ADAMS, MD
Chairman

Consent

Notwithstanding my voluntary and knowing execution of this Consent, I do not concur in the findings of fact and conclusions of law made by this Commission.

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses in my own behalf and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Board that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation I may suffer the revocation or suspension of my license to practice medicine in Maryland.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

CORAL GORDON, MD

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:

I HEREBY CERTIFY, that on this 21st day of November, 1978, before me, the subscriber, personally appeared CORAL GORDON, MD and she made oath in due form of law that the foregoing Consent is her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

ARLINE JOHANNSEN
Notary Public

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Commission on Medical Discipline
201 W. Preston St.
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Dear Commission Members:

Please be advised that I have decided to discontinue the practice of medicine. In accordance with that decision, 30 days from the date of this letter, I will terminate my practice of medicine and tender my license to the Commission. During this 30-day period, I will accept no new patients, will prescribe no Class II drugs, will cease dispensing drugs and will permit persons designated by the Commission to inspect my office and practice at any reasonable time. My decision to return my license and to discontinue the practice of medicine has, as you know, been prompted by an investigation of my medical practice conducted by the Commission on Medical Discipline. I recognize that the Commission has charged me with violation of Article 43, Sections 130 (h) (4) and (18) of the Maryland Code (crime involving moral turpitude, professional, physical and mental incompetence). I further realize that if the Commission's consideration of this matter had proceeded to completion, the Commission believes that it would have been able to substantiate that I am professionally incompetent to practice medicine, and that I plead guilty to a crime involving moral turpitude.

In executing this letter and agreeing to return my license to the Commission, I recognize and agree that my status as a resignee is the same as that of a person whose license has been revoked following a hearing before the Commission. In other words, I agree that if, in the future, I determine that I would like to once again practice as a physician, I will, at that time, approach the Commission in the same posture as one whose license has been revoked for the reason above set forth. In such event, I have been advised by the Commission that it will consider any evidence I might tender.

Finally, it should be pointed out that I have discussed this letter with my attorney and understand its import.

Very truly yours,

ALBERT BURWELL, MD

STATE OF MARYLAND

to wit:

CITY OF BALTIMORE

On this 11th day of July, 1978, before me, the undersigned officer, personally appeared ALBERT BURWELL, MD, and he made oath in due form of law that the foregoing is his voluntary act and deed.

As witness, my hand and notarial seal.

KATHLEEN C. BALL

Notary Public

My Commission expires: July 1, 1982.

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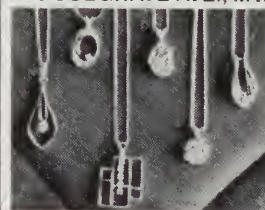


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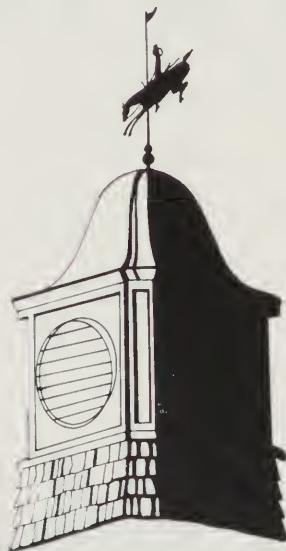
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Executive Director's Newsletter

July, 1979

PHYSICIANS

ALERT

The Committee on Drugs has noted that many physicians prescribe Preludin as an anorectic drug for weight control. While this drug is not an amphetamine and therefore not covered under the State amphetamine regulations, its use should be extremely limited. Its actions include central nervous system stimulation and elevation of blood pressure. Preludin may be used in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. Contraindications include advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, etc. Tolerance usually develops within a few weeks and when this occurs, the recommended dose should not be exceeded in an attempt to increase anorectic effect; rather, the drug should be discontinued. See your PDR for further details.

COMPLIMENTS,

COMPLIMENTS

During the first week in June, the Faculty received several letters from patients expressing their appreciation of services rendered to them by their physicians. In addition, the Faculty has also received complimentary letters from physicians expressing their pleasure with services offered to them by the Faculty.

NEW

PHARMACY

ASSISTANCE

PROGRAM

Individuals who are not eligible for full Medicaid benefits can now apply for assistance under the Maryland Pharmacy Assistance Program. Individuals may receive an income higher than an ordinary Medicaid recipient and qualify for these benefits. Income limitations are: \$4,100 for a single person, \$4,600 for two persons, and a graduated scale for additional individuals in the family unit.

Under this program, an individual must pay \$1.00 for each prescription and each refill and the State pays the rest.

Further details can be obtained from the Faculty office, the Department of Health, the Pharmacy Association or the local Department of Social Services.

RESOLUTIONS

DEADLINE

Resolutions for consideration at the Faculty's Semiannual meeting of its House of Delegates must be in the Faculty office AT LEAST EIGHT WEEKS PRIOR TO THE DATE OF THE MEETING. This would mean that all resolutions must be received prior to the close of business on

FRIDAY, AUGUST 3, 1979.

INTERPRETERS
NEEDED

Several years ago, the Auxiliary of the Faculty developed a list of individuals who could converse in foreign languages. This was, and is used for communication between a physician and patient who may have difficulty in expressing physical complaints or symptoms in English.

The Faculty is attempting to update this listing so it can respond to queries from physicians, hospitals, and others who are in need of an interpreter. If you or your spouse can perform this public service in behalf of the Faculty, would you please drop us a note to "Foreign Language" at the Faculty or telephone us at (301) 539-0872, indicating what special language skills you have.

SEMIANNUAL
SESSION

Plans are now underway for the Semiannual session to be held in New Orleans, Louisiana, September 12-16, 1979. The House of Delegates session will be held in Baltimore at the Faculty Building on Saturday, September 29, 1979 commencing at 2 PM. The General Meeting of the Faculty will be held immediately following adjournment of the House meeting.

Reservations for the New Orleans meeting should be made through the Travel Guide Agency (Patricia Orem; 727-1811). Cost of the entire trip, including air fare, baggage handling, airport transfers in New Orleans, a welcome cocktail party, a breakfast at Brennans, and a farewell dinner - \$489 per person.

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IN
JULY

A Practice Management Workshop for established physicians to improve appointment scheduling, increase collections, develop effective personnel policies, and reduce paperwork has been scheduled for Wednesday, July 18, at the Quality Inn, Towson. The workshop qualifies for 8 Category I CME credits. Registration is \$85.00 and spouses may audit for \$10.00. Reservations should be made with Mary Galeckas at the Faculty office.


PHYSICIAN
FEE AND
COST
INDICATORS

Physician Fee and Cost Indicators is included as an insert in the May 18, 1979 issue of AM NEWS. This booklet is an attempt to assist physicians in tracking costs and fees.

The first part of a dual system, the Physician's Fee Index (PFI) presents a method to measure the approximate overall rate of increase in your fees—for your information and for comparison with other economic gauges (such as the Consumer Price Index).


John Sargeant

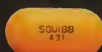
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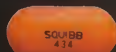
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Procainamide Hydrochloride Tablets

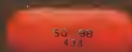
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See following page for brief summary

PRONESTYL® TABLETS

Procainamide Hydrochloride Tablets

The prolonged administration of procainamide often leads to the development of a positive anti-nuclear antibody (ANA) test with or without symptoms of lupus erythematosus-like syndrome. If a positive ANA titer develops, the benefit/risk ratio related to continued procainamide therapy should be assessed. This may necessitate considerations of alternative anti-arrhythmic therapy.

DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of over-dosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been

reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Pronestyl Tablets (Procainamide Hydrochloride Tablets) providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride are available in bottles of 100 and Unimatic® single-dose packaging in cartons of 100. The 250 mg and 500 mg tablets are also available in bottles of 1000.



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The Louis A. M. Krause History of Medicine and Rare Book Collection

During my one-and-a-half years as Faculty Librarian and contributor to this column, I have said virtually nothing concerning the Faculty Library's History of Medicine and Rare Book Collection. This collection consists of approximately 17,000 volumes, including antique and rare medical texts, as well as current materials related to the history of medicine. Also included are many manuscripts and archival materials, such as minute books, day books and ledgers from early Maryland hospitals and physicians' practices, and notebooks of medical students, dating back to the mid-18th Century. For this column, I have selected a few of the rarest treasures belonging to the Faculty to describe briefly and show their importance to medicine.

First, however, some comment is due concerning the manner in which this enviable collection was assembled. The Faculty Library dates back officially to July 1, 1830, and next year will be its 150th anniversary; however, the prospect of a medical library for privately-practicing physicians was on the minds of the Faculty's founding physicians as early as 1798. To provide for the dissemination of medical information throughout Maryland is one of the charges laid upon the Faculty in its 1798 Charter.

The Faculty Library was built up mainly from the contributions of member physicians. Among the Faculty's rare books are some bearing the signatures or bookplates of many of the founding physicians; for instance, the Faculty Library possesses the entire libraries of Upton Scott, the first President of the Faculty, and John Archer, who prefigured the goals of the Faculty with his apprenticeship school and medical society in Harford County during the early years following the American Revolution. Many of the items that were standard texts and reference sources during the period of the founding of the Faculty are today extremely rare and valuable.

The tradition of building up the Library's collection through contributions of personal collections continued throughout the Faculty's history; indeed, few of the rare items in the Faculty's History of Medicine collection were purchased. This is true of the three medical incunabula in the Faculty Library's possession, as well as its first, second, third and fourth editions of Vesalius and its copy of the first edition of Withering's *Account of the Foxglove*. In 1974, the Faculty Council appropriately named the historical and rare book collection after the late Louis A. M. Krause, MD, who served for many years as Chairman of the Faculty's Library Committee.

When a medical historian or book collector visits a collection of rare medical books, one of his first questions is likely to be, "What incunabula do you have?" The Faculty Library possesses three items in this category; that is, books printed before 1501. The medical books of this period constitute the current medical literature of the last third of the 15th Century, and also the first printed editions of the classics of the prior 19 centuries that had previously circulated only in manuscript form.

The oldest book in the Faculty's collection is *Liber Metricus de Pulsibus cum Commentarie Gentilis Fulginatis*, by Aegidius Corboliensis (also known as Gilles de Corbeil, 1165-1213), published in Padua in 1484 by Matthaeus Cordonis de Windischgretz. Aegidius, a graduate of Salerno, was physician-in-ordinary to King Philip of France. He is best known for his two poems, *De Pulsibus* and *De Urinis*. Gentilis Fulgino, whose commentary accompanies *De Pulsibus* in this edition, was the most celebrated physician of his time, serving as Professor of Medicine at Ferrara and at Padua. He died a victim of the plague in 1349.

Aurelius Cornelius Celsus lived and wrote in the 1st Century AD. His Latin style earned him the title "Cicero Medicorum." His

monumental *De Medicina* was the greatest medical treatise to come from ancient Rome and the first western history of medicine. The Library's copy was published in Venice by Philippus Pincius for Benedictus Fontana in 1497 and was already the fourth edition of this great work. In *De Medicina*, Celsus categorizes diseases according to methods of treatment: diet, regimen, drugs and surgery. Celsus was the first to discuss the treatment of insanity and heart disease, for which he suggests treatment by diet and regimen. *De Medicina* also contains the first accounts of the use of ligature, the earliest discussion of surgical remedies for mutilations (plastic surgery) and excellent descriptions of lateral lithotomy and herniotomy.

Petrus de Abano lived during the last half of the 13th Century and early 14th Century. The Library owns a copy of his *Treatise on Poisons*, published in Leipzig in 1498, the fifth printed edition. Petrus de Abano's works illustrate the speculative nature of medicine during his time. Among the subjects he discusses are: "Is the brain of hot or moist complexion?" "Is manhood better than childhood? or youth?" "Is life possible south of the equator?" "Is the white of the egg hot and the yolk cold?" De Abano was called "the great conciliator" for his attempts to bring religion, philosophy and medicine together in a rational synthesis; however, this got him into trouble with the Inquisition, and he died while on trial for blasphemy. The court found him guilty, anyway, and his corpse was burned at the stake.

To fully appreciate the antiquity and importance of these three earliest items in the Faculty Library, one should recall that all were printed, and used by physicians, during the same period that Columbus was making his voyages to the New World.

After inquiring about and examining the incunabula in a collection of rare medical books, a visitor's next question frequently is, "Do you have a Vesalius?" *De Humani Corporis Fabrica Libri Septem*, by Andreas Vesalius, published in Basel by Johannes Oporinus in 1543, has been called "The greatest and most beautiful book in the history of medicine." The Faculty Library is fortunate to own a very fine copy of the 1543 first edition, and also a copy of the 1555 second edition. Each contains a beautiful woodcut title page, a portrait of Vesalius, 19 full-page woodcuts, and hundreds of smaller historiated initials and woodcuts based upon drawings by Vesalius and artists from the school of Titian. (Historical scholars today attribute most of the woodcuts to John Stephen of Calcar.)

Because of its unique blend of illustrations, text and typography, *De Humani Corporis Fabrica* is one of the most beautiful and magnificent volumes in the history of all printing. It stands unsurpassed as a work of creative art in the true spirit of the Renaissance.

The first edition was published the same year as Copernicus' *De Revolutionibus* and had as much, or greater, effect on medicine and man's knowledge of himself as Copernicus' work had on astronomy and the concept of man's place in the universe. Vesalius founded modern observational science and research by teaching physicians how to derive accurate information about the anatomy and physiology of the human body from actual dissection and careful observations.

Bernardus Eustachius lived in the same period as Vesalius. Had his anatomical copperplates been published in 1552 when they were completed, Eustachius would have ranked at least equally with Vesalius as one of the founders of modern anatomy. Eustachius died before he was able to publish his *De Dissensionibus ac Controversiis Anatomicis*, for which he had prepared 39 copperplates. The plates were passed on to Eustachius' relatives and were thought lost until discovered in the early 18th

Century by the great Papal physician Lancisi. In 1714, Lancisi published the plates along with his own commentaries. Eustachius' original commentaries have never been found.

The Library owns a very fine copy of the 1714 edition of Eustachius' *Tabulae Anatomicae*, published in Rome by Francisci Gonzague under the supervision of Lancisi. Eustachius is known for his discovery of the Eustachian tube, the thoracic duct, the adrenals and the abducens nerve. He also gave the first accurate descriptions of the uterus, the cochlea, the muscles of the throat and the origin of the optic nerves. He surrounded his illustrations with graduated scales instead of printing letters on the figures; the numbers on each frame provided coordinates for the pictured space so that any anatomical part could be described in the text and easily located in the illustrations.

One of my own favorite early medical books is Jacob Rueff's *De Conceptu et Generatione Hominis*. The Library's copy is the second Latin edition and the first edition with illustrations by Jost Amman, published in Frankfurt by Sigismund Feyerabend in 1580. Rueff's work was intended to be a guide for midwives. It gives a comprehensive picture of obstetrical knowledge during the early 16th Century, including the current state of embryology and knowledge of birth defects. The Amman woodcuts are what makes this book most attractive to me. They illustrate many aspects of childbirth, including the engaging of a midwife by a woman having the first signs of pregnancy, the delivery of the child using a birthing stool and the husband and wife celebrating their good fortune. The illustration of the childbirth scene is especially amusing because, while the female midwife and her two female assistants surround the mother-to-be in the birthing stool and are busy assisting her, the husband and another man (perhaps the physician) are shown near a window in the background doing the really important work—they are studying the stars and casting the new baby's horoscope! Also, in the illustration on the title page, which attempts to portray several different stages of childbirth in a single illustration, what is interpreted to be the final scene depicts the midwife enjoying a large tankard after the successful delivery.

William Hunter labored for 30 years to produce his classic *Anatomia Uteri Humani Gravidi Tabulis Illustrata, The Anatomy of the Human Gravid Uterus, Exhibited in Figures*. This is a very large folio consisting of 34 copperplates by Jan van Rymsdyk and Robert Strange, each with a facing explanation leaf with text in English and Latin. The Faculty Library owns two copies of the first edition, printed by John Baskerville in Birmingham, England, in 1774. This is one of the most beautiful anatomical atlases ever published, anatomically exact and artistically perfect. It is one of the very few great medical books issued by a private press. Its original price of six guineas was a huge sum, even for physicians, in 1774.

Foxglove (*digitalis purpurea*) was used empirically by herbalists for hundreds of years to treat dropsy and chest pains. It was not until 1785, however, that its efficacy was scientifically established. In that year William Withering published *An Account of the Foxglove and Some of Its Medical Uses*. The book contains 207 pages, and one large, folding, hand-colored plate of *digitalis purpurea*. It was published in Birmingham, England, by C.G.J. and J. Robinson. The Library's copy, with the foxglove illustration facing left, is considered to be the first edition, first state, of this great work. The book is a pharmacological classic in that it reports one of the first modern clinical studies of a drug. Withering summarized 10 years of careful research on *digitalis*, and as a result the action of the drug in dropsy and on the heart became generally recognized and accepted by the medical profession. Withering honestly recorded both the successes and failures in his trials with the drug. He learned to employ *digitalis* only in selected cases of dropsy, and he stressed that the dose must be carefully adjusted. He described the signs and symptoms of *digitalis* toxicity and established clear guidelines for rational use.

The greatest and most beautiful atlas of pathology was produced in 40 serial parts by Jean Cruveilhier between 1829-42. These parts are known collectively under the title *Anatomie Pathologique du Corps Humain, ou Descriptions, avec Figures Lithographiées et Coloriées, des Diverses Altérations Morbides dont le Corps Humain est Susceptible*. This great work includes 333 brilliantly hand-colored lithographed plates. The sections

were published in Paris by Baillière.

Cruveilhier obtained his autopsy material in the deadhouse of Salpêtrière and the Musée Dupuytren. In this work, Cruveilhier first described disseminated sclerosis, Cruveilhier's palsy, hypertrophic pyloric stenosis and ulceration of the stomach due to hyperacidity. The atlas also contains remarkable plates of a cerebellopontine angle tumor and falx meningoma.

One of the best known of all early American medical classics is William Beaumont's *Experiments and Observations on the Gastric Juice, and the Physiology of Digestion*, with three text illustrations of a gastric fistula. The Library has three copies of the first edition, published by F. T. Allen in Plattsburg, NY, in 1833. Beaumont was a surgeon in the US Army. A young French-Canadian voyageur, Alexis St. Martin, developed a permanent gastric fistula, the result of a gunshot wound. In caring for St. Martin, Beaumont recognized the unique opportunity to study digestion and the movements of the stomach "in vivo." The work is a classic in physiology.

Between 1847-49, Ignaz Philip Semmelweis published his initial papers showing puerperal fever to be a septicemia. Even though Semmelweis' prescription for the washing of physicians' hands in calcium chloride solution before the examination of childbed cases resulted in a reduction of five-sixths in infant mortality, the ridicule, opposition and persecution that greeted Semmelweis' papers forced him to flee from Vienna to Budapest. He continued his work in Budapest and became Professor of Obstetrics at the University there. In 1861, his monumental work, *Die Aetiologie, der Begriff und die Prophylaxis des Kindbettsiebers*, was published by C. A. Hartleben in Budapest.

The American, Oliver Wendell Holmes, was five years ahead of Semmelweis in determining that childbed fever was spread from one obstetrical patient to another by the unwashed hands and clothes of attending physicians. Semmelweis was completely unaware of the work of Holmes. Still, the work of Semmelweis is superior to that of Holmes in that he recognized puerperal fever as a blood poisoning of septicemia. While *Die Aetiologie* is a monumental work, Semmelweis was a very poor writer; his book is difficult to read and filled with masses of badly-presented statistics. Because Semmelweis' ideas were unpopular and his reactionary and jealous colleagues fiercely opposed them, the publisher ran a very small edition of the work; even so, the majority of the copies went unsold and were probably sent to a papermill to be pulped and recycled. This accounts for the *Aetiologie's* being one of the rarest and most difficult to obtain of all medical texts. The Faculty's copy of *De Aetiologie* is very fine, with the original paper covers bound in.

This small group of commentaries hardly does justice to the extensive collection of rare medical books that are part of the heritage of the privately-practicing physicians who constitute the membership of the Faculty. The 17,000 volumes in the Louis A. M. Krause Collection in the Faculty Library represent the finest thinking and practices of physicians throughout 2-3,000 years, and this fine collection continues to grow in importance and value through the gifts of Faculty members today, not only of items from their own private libraries, but also of autographed copies of their own written contributions to the advance of medical progress.

Lack of space prevents discussion of the manuscripts and archives in the Faculty Library's History and Rare Book Collection at this time, but that can wait for another column.

JOSEPH E. JENSEN
Librarian

DOCTORS TAKE NOTE:

July 7-14, Natl. Mtg. of Amer. Soc. of Clin. Pathologists, Shoreham Americana Hotel, Wash., DC. For details, call Robt. Florzak at (312) 738-1336.

July 31 is the deadline for submission of entries to the 1979 Amer. Acad. of Pediatrics Journalism Awards Prog. For details, call Joanna Hague at (312) 869-4255, ex. 18.

New Book Titles

Available now for your use from the Med-Chi Library.

Attitude to Death

- WT Baer, Louis Shattuck
104.3 **Let the Patient Decide: a Doctor's Advice to Older**
.B 141 **Persons.** Phila., PA, Westminster Press, 1978.
1978
- BF Benton, Richard G.
789 **Death and Dying.** New York, Van Nostrand, 1978.
.D 4
.B 478d
1978

Clinical Competence

- W Green, Robert Castleman
21 **The Care and Management of the Sick and Incompetent**
.G 797c **Physician.** Springfield, IL, Thomas, 1978.
1978

Contraception

- WP **Contraceptive Technology, 1978-79.** Edited by Robert
630 A. Hatcher. 9th rev. ed. New York, Irvington Pub.,
.C 764 Inc., 1978.
1978

Eye Diseases

- WW Fedukowicz, Helena Biantovskaya
100.3 **External Infections of the Eye.** 2d ed. New York,
.F 294e Appleton-Century-Crofts, 1978.
1978

Family Practice

- WB **Family Medicine: Principles and Practice.** Ed. by Robert
110 B. Taylor. New York, Springer-Verlag, 1978.
.F 197
1978

Fetal Alcohol Syndrome

- WQ Bureau of Alcohol, Tobacco and Firearms
211 **The Fetal Alcohol Syndrome Public Awareness Cam-**
.B 952f **paign 1979.** Wash., DC, 1979.
1979

Genital Neoplasms, Female

- WP McGowan, Larry
140 **Gynecologic Oncology.** New York, Appleton-Century-
.M 146g Crofts, 1978.
1978

Kidney Failure

- WJ **Strategy in Renal Failure.** Ed. by Eli A. Friedman.
342 New York, Wiley, 1978.
.S 898
1978

Knee Injuries

- WE Smillie, Ian Scott
870 **Injuries of the Knee Joint.** 5th ed. New York, Long-
.S 641i man, 1978.
1978

Legislation, Hospital

- WX Warren, David G.
32.1 **Problems in Hospital Law.** 3rd ed. Germantown, MD,
.W 287p Aspen Systems Corp., 1978.
1978

Lung Diseases

- WF Stone, Daniel Joseph
600.3 **Practical Points in Pulmonary Diseases.** Garden City,
.S 877p NY, Medical Examination Pub. Co., 1978.
1978

Malpractice

- W Lombardi, Tarky
44 **Medical Malpractice Insurance.** Syracuse, NY, Syra-
.L 842m cuse Univ. Press, 1978.
1978

Multiple Sclerosis

- WL **Multiple Sclerosis: a Critical Conspectus.** Ed. by E.J.
360 Field. Balto., Univ. Park Press, 1977.
.M 956
1977

Neuroses

- WM Gary, Melvin
170.3 **Neuroses: a Comprehensive and Critical View.** New
.G 781n York, Van Nostrand, 1978.
1978

Nuclear Medicine

- WN Rocha, Antonio Fernando Goncalves da
440 **Textbook of Nuclear Medicine.** Phila., PA Lea and
.R 672t Febiger, 1978.
1978

Pharmacology

- QV Csaky, T.Z.
4.3 **Handbook of Pharmacology.** 6th ed. New York, Ap-
.C 958h pleton-Century-Crofts, 1978.
1979

Physicians, Women

- W Walsh, Mary Roth
21 **Doctors Wanted: No Women Need Apply.** New
.W 226d Haven, Yale Univ. Press, 1977.
1977

Rape

- WM Halpern, Susan
401 **Rape: Helping the Victim.** Oradell, NJ, Med. Econ-
.H 195r omics Co., 1978.
1978

Rhinoplasty

- WV Sheen, Jack H.
312 **Aesthetic Rhinoplasty.** St. Louis, Mosby, 1978.
.S 542a
1978

Skin Diseases

- WS Korting, G.W.
260 **Diseases of the Skin in Children and Adolescents.** 3rd
.K 85d ed. Phila., PA, Saunders, 1979.
1979

Sleep Disorders

- WM **Sleepy Disorders: Diagnosis and Treatment.** New York,
188 Wiley, 1978.
.S 632
1978

Surgery

- WO Brooks, Shirley Marie
517 **Instrumentation for the Operating Room.** St. Lou-
.B 873i Mosby, 1978.
1978
- WO Med. Coll. of WI. Dept. of Surg.
140 **Manual of Surgical Therapeutics.** 4th ed. Boston, Lit-
.M 489m tle, 1978.
1978

Writing

- WZ King, Lester S.
345 **Why Not Say It Clearly?** Boston, Little, Brown,
.K 53w 1978.
1978

Football Injuries:

Articles Available Through the Med-Chi Library



Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to members of the Faculty during the month of April, 1979:

1. Voice disorders: Evaluation and management, an update 18 citations
2. Essentials in the care of the elderly 14 citations
3. Allergic type reactions to radiographic contrast media and allergy diagnosis by RAST 17 citations
4. The role of total joint replacement in the management of arthritis 15 citations
5. Urinary tract infections—current concepts 18 citations
6. Current topics in vascular surgery 13 citations
7. Advances in nuclear medicine for the practicing physician 15 citations
8. The medical record, an absolute in medical care 17 citations
9. PSRO and its effect on your practice 13 citations
10. The problem-oriented medical information system: The patient's record and the computer in primary care and clinical research 14 citations

If you would like a copy of one of these searches or would like to have a search on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
Assistant Librarian

"Football, Neck Muscles and Head Impact," by Reid, S.E. and Reid, S.E., Jr. **Surg. Gynecol. Obstet.** v.47(4):513-7, October, 1978.

"Football Fatalities in Actuarial Perspective," by Clarke, K.S. and Braslow, A. **Med. Sci. Sports.** v.10(2):94-6, Summer, 1978.

"Oklahoma High School Football Injury Study: A Preliminary Report," by Moretz, A. 3d. and others. **J. Okla. State Med. Assoc.** v.71(3):85-8, March, 1978.

"Injuries in High School Sports," by Garrick, J.G. and Requa, R.K. **Pediatrics** v.61(3):465-9, March, 1978.

"Injury Prediction in the Young Athlete: A Preliminary Report," by Jackson, D.W. and others. **Am. J. Sports Med.** v.6(1):6-14, January-February 1978.

"The Role of the Trainer in Modern Athletics," by Arnold, J.A. and Yeber, D. **J. Arkansas Med. Soc.** v.74(9):346-50, February, 1978.

"Spinal Injury at the Level of the Third and Fourth Cervical Vertebrae from Football," by Torg, J.S. and others. **J. Bone Joint Surg. (Am)** v.59(8):1015-9, December, 1977.

"Burning Hands in Football Spinal Cord Injuries," by Maroon, J.C. **JAMA** v.238(19):2049-51, Nov. 7, 1977.

"Upper Trunk Brachial Plexus Injuries in Contact Sports," by Clancy, W.G., Jr. and others, **Am. J. Sports Med.** v.5(5):209-16, September-October, 1977.

"New Football Rules and Athletic Injuries," by Arnold, J.A. and Coker, T.P. **J. Arkansas Med. Soc.** v.74(4):163-5, September, 1977.

"Severe and Catastrophic Neck Injuries Resulting from Tackle Football," by Torg, J.S. and others. **Del. Med. J.** v.49(5):267-8, 271-3, 275, May, 1977.

"A Method for the Management of Cervical Injuries in Football: A Preliminary Report," by Andrish, J.T. and others. **Am. J. Sports Med.** v.5(2):89-92, March-April, 1977.

"Severe and Catastrophic Neck Injuries Resulting from Tackle Football," by Torg, J.S. and others. **J. Am. Coll. Health Assoc.** v.25(4):224-6, April, 1977.

"Etiology of Traumatic Spinal Cord Injury: Statistics of More Than 1,100 Cases," by Carter, R.E. Jr. **Tex. Med.** v.73(6):61-5, June, 1977. □

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Medicine in Maryland, 1634–1900

Editor: Douglas G. Carroll, Jr., MD (1915–1977)

Chapter 14

Medicine in Maryland During the Civil War

"We operated in old blood-stained and often pus-stained coats, the veterans of a hundred fights. We operated with clean hands in the social sense, but they were undisinfected hands. . . . We used undisinfected instruments from undisinfected plush-lined cases, and, still worse, used marine sponges which had been used in prior pus cases and had been only washed in tapwater. If a sponge or an instrument fell on the floor, it was washed and squeezed in a basin of tapwater and used as if it were clean."
W. W. Keen¹

The history of medicine in Maryland during the Civil War is largely a story of the battles, the care of the wounded and the military hospitals. The scientific advances based on war experience were largely in sanitary reform rather than improvement in the treatment of individual patients with surgery or medication. The demonstration of the necessity for sanitary reform in camps, hospitals and on the march was a preparation for the public health movement in the last part of the 19th Century. Many of the leaders in this movement had been convinced from war experience about the importance of clean camps, clean quarters and clean water. These matters are, however, part of the history of medicine in the United States rather than Maryland.

In this chapter, we have tried to give the story of a desperately-wounded Maryland soldier and how he was treated on the battlefield; we have attempted to describe the Battle of Sharpsburg from a medical point of view (including preparation, reports from the front and hospital experience); the dispersal of the wounded after the Battle of Gettysburg, the Battle of the Monocacy and the Union military hospitals in Maryland during the Civil War.

How A Wounded Man Was Cared For

An account of how a wounded man was cared for reveals many of the battlefield realities of the Civil War. The wounded man was a Marylander, Major Richard Snowden Andrews, CSA, commanding the First Maryland Artillery (Andrews Battalion). The battle was that at Cedar Creek, VA, Aug. 19, 1862. In this battle, the Confederates were so hard-pressed by superior numbers that General Thomas "Stonewall" Jackson drew his sword and rallied his men. The enemy finally was defeated.

Maj. Andrews advanced his guns in the face of a charging column of infantry and drove it from the field. Here, however, soon after Gen. Winder was struck, Andrews, too, received what was probably the worst wound any man ever survived. A piece of shell struck the lower part of his right side, tearing apart the wall of the abdomen. With wonderful presence of mind, he

pressed his hand over the wound, then threw his other arm around his horse's neck so that he could fall to the ground on his back to keep from being disemboweled. He laid on the dusty roadside for two to three hours . . . Gen. A.P. Hill, who was bringing up troops on the other side of the fence under cover of the woods, stopped for a moment to find out who it was, and promised to send an ambulance and surgeon at the first possible moment . . . it was not until after a long period of waiting that a surgeon came riding by with his attendants and stopped to examine the wound. He told (Andrews) frankly that there was no hope, for the shell had torn deep through the abdomen even to the intestines. As he was riding away (Andrews) called to him to say that once while fox-hunting he had seen a valuable dog almost disemboweled in getting over a fence, that he had taken him home and cared for him and the dog had lived to hunt again. This touched the heart of the surgeon and it was not long after this that an ambulance was sent. (Andrews) requested that instead of taking him to the usual place (a field hospital), he might be taken to the farmhouse where he had spent the previous night sleeping on the porch beside Gen. Jackson. Arrived at the farmhouse, they laid him on the floor and as no Army surgeon was at hand, they went out and stopped a country doctor, Dr. Amos, who was passing. On looking at the wound, Dr. Amos said there was nothing to be done and there was no chance for life. (Andrews) said "Isn't there a chance in 10, or 20 or even a hundred?"

"Well," replied Dr. Amos, "Since you are so plucky, I'll do the best I can for you," thinking to himself that he would at any rate make the body more sightly. He then washed out grit and bits of cloth from the wound and proceeded to sew it up, using the only needle he had, which was a rusty one, and having no anesthetic or disinfectants. Then he was placed on the bed and, as I said before, there was no further treatment possible except applications of cold water.²

This description of Andrews' care reveals in a remarkable way the attitude toward death and wounding during a major battle. Andrews subsequently recovered completely, but he had to persuade the Army surgeon to get him an ambulance by telling a story about a dog he had saved. Later, a local physician had to be called in and persuaded to sew up his abdomen. Death was taken for granted. It was assumed that for certain wounds nothing whatsoever could be done, and the patient was left to die as best he could on the battlefield. Such treatment of an American soldier on a present day battlefield would call for a Congressional investigation.

Adams (1) notes that abdominal wounds in the Civil War kept surgeons humble, since no earthly intervention seemed to help. The overall mortality for abdominal wounds was 87%, 100% for small intestinal wounds. Survival rate was about 59% in wounds of the large intestine.

Probably 150,000 Southern soldiers lost their lives during the War. Only about 50,000 were attributable

to battle wounds. The Union figures are 224,586 deaths owing to disease and 110,070 to the battlefield.²

In the Sharpsburg Campaign, 8,724 Confederate soldiers were wounded. The highest recorded losses in casualties during the Civil War were those of the Union's First Minnesota at the Battle of Gettysburg, where there were 85.5% casualties. In the same battle, the Confederates' 26th North Carolina probably suffered greater losses, but their records were so poor that the actual report gave only 71.7% killed and wounded.³

Civil War Battles Fought in Maryland

Two crucial battles of the Civil War were fought in Maryland, and one just beyond its northern border at Gettysburg. Each was part of an unsuccessful invasion of Maryland by Confederate troops. At Sharpsburg (also known as Antietam, Sept. 17, 1862), the bloodiest day in American history (20,000 casualties), the Northern Army under Gen. George McClellan turned back Gen. Robert E. Lee's veterans at a cost which lost the campaign for the South. At Gettysburg (July 1-3, 1863) the Northern Army under Gen. George G. Meade again turned back Lee at a terrible cost (43,500 casualties). The third, at the Monocacy near Frederick (July 9, 1864), was hardly more than a skirmish (1,590 casualties). Gen. Jubal A. Early's Confederate troops routed Gen. Lewis Wallace's Union forces, but Early's troops were delayed long enough to prevent the capture of Washington.

From each of these battles, the wounded were cared for in Maryland, sometimes in established army hospitals at Baltimore, sometimes in tents, churches or houses on the battlefield.

The surgeons of the Civil War possessed little more skill than those of the Revolutionary War. Chloroform, when available, was an excellent anesthetic and the use of quinine in malaria was better understood. Phlebotomy, calomel and cathartics as items of therapy were no longer popular. The real medical advances resulting from the Civil War were the carefully collected statistics in the *Medical and Surgical History of the War of the Rebellion*,⁴ the realization of the importance of sewage disposal, pure water and sanitary engineering, not only in war but in civilian life and the development of the Medical Department of the US Army.

The Sharpsburg Campaign (Antietam, Sept. 17, 1862)

1862 was a disastrous year for the Union on the battlefields of Virginia. In May and June, Stonewall Jackson, strange college professor and Presbyterian deacon, had defeated three Union armies operating in the Shenandoah Valley. He had denied 60,000 Union troops needed by McClellan in his attack on Richmond.

By July, Lee and Jackson had shredded McClellan's tremendous army attacking Richmond from the East. Charles S. Tripler had been Union Medical Director during this campaign. The medical care, hospitals and transportation of wounded had all been fumbling and inadequate, not owing to any fault on Tripler's part, but because the Medical Department

was a low priority on receiving transportation and supplies and depended upon inexperienced volunteers. In his report on the campaign, Tripler attacked his critics with vigor and was replaced by Jonathan Letterman as Medical Director on July 4, 1862.

On Aug. 29th and Sept. 1st, on the old Bull Run Battlefield, Lee routed Gen. John Poper's Army of Virginia attacking Richmond from the North. Here the care of the wounded was incredibly inept. Surgeon Thomas A. Parlin, the Medical Director in charge, was completely unprepared. There were insufficient ambulances; the hospitals were poorly-placed and understaffed. Destroyed roads and bridges made movement of the wounded difficult. Civilian ambulance drivers, hired by the Quartermaster Corps, simply ran away terrified; 3,000 wounded lay where they had fallen three days after the battle. Despite the cooperation of the Confederate Surgeons, the last Union wounded were not picked up for seven days.

Following this disaster, Surgeon Gen. William Alexander Hammond concluded that the Army must have an Ambulance Corps responsible to the Medical Department rather than to the Quartermaster Corps.

Since his appointment as Medical Director in July, Letterman had spent his time organizing and training an effective Ambulance and Hospital Corps which had the necessary support of Hammond.

Sharpsburg was Letterman's opportunity. He had a clear idea of how the Medical Department should be organized and was a good administrator, but above all, was lucky that the battle was a Union victory, that the roads and communications were relatively good, that the Union Army remained in control of the battlefield and that there were multiple sources of supplies from New York, Philadelphia, Baltimore and Washington.

The result was that Letterman was able to realize his plan for the Army of the Potomac Ambulance Corps, which was made up of ambulances taken from smaller units and organized into Corps and Division Units and manned by a group of soldiers especially trained and assigned to the Medical Department.

There were shortages of medicines, instruments, dressings and stores. Very few medical officers had been able to renew their supplies and were worn down by their labors. It was necessary to prepare for the campaign in Maryland as quickly as possible. Hospital wagons were directed to report to Frederick on Sept. 13th; supplies were ordered from Baltimore. The decision to establish hospitals in Frederick was made on Sept. 13th. Most medical supplies had been removed or destroyed by Confederate troops, who left the city the day before Letterman's arrival (Jonathan Letterman's report on the Sharpsburg Campaign).⁴ The destruction of the bridge at the Monocacy River interrupted railroad connection between Frederick and Baltimore.

The medical supplies of the Confederate Army were of course far more depleted than those of the Union Army. Supplies captured at Harper's Ferry, just before the battle were of no help. In addition, the men were ragged, shoes were deplorable and food was insufficient in amount and quality.

The battle was fought along the Sharpsburg-Hagerstown Rd., running almost due north through the town of Sharpsburg in Western Maryland. The road was just to the west of Antietam Creek, which the Union Army had to cross to attack the Southern Army along the road. Behind the Southern Army was the Potomac River, passable only at a few fords.

The Maryland Campaign had started when Lee's troops had crossed the Potomac on Sept. 5-6th at White's Ford 25 miles northwest of Washington. (In 1934, the author, while exploring White's Ford, with the late Civil War authority, R.E. Lee Marshall, met a Mr. Curley who had seen the troops cross in 1862. The men were ragged and thin, but enthusiastic.) He advanced north toward Frederick. Because his army was divided (Jackson captured Harper's Ferry), he withdrew behind South Mountain, rapidly, decisively followed by the Union Army under McClellan.

There were two passes (Turner's Gap and Crampton Gap) through South Mountain which the Confederates defended as they withdrew to the west. The unexpected decisiveness of McClellan, the Union commander, was explained by the fact that he had in his possession a complete copy of Lee's plans for the campaign. These orders were found, wrapped around some cigars, by a Union soldier. Their importance was recognized and they were taken to McClellan. To this day their loss has not been explained.

On Sept. 14th, the Battle of South Mountain occurred. Churches and other buildings in Middletown, as well as houses and barns in the vicinity of the battle, were taken to receive the wounded. These hospitals were inspected by Letterman on the night of the battle. On the following morning, surgeons made rounds of the hospitals to consult on those patients needing immediate surgery. The local ladies assisted in caring for the wounded.

The Battle of Crampton's Gap occurred on the same day (Sept. 14th). Hospitals for the wounded were located at Burkettsville about a mile from the battlefield. About 1,800 Confederates and a like number of Federals were wounded or died in these two engagements.

On the night of the 15th, Letterman reached the site of what proved to be the Battle of Sharpsburg. A survey of the countryside with the positions of the troops was made, and corps medical directors were instructed to form their hospitals by divisions. The most appropriate type of housing for the wounded was a large, well-ventilated barn with plenty of hay, straw and water.

The battle began on the evening of Sept. 16th, was renewed on the 17th and continued until night.

The Battle of Sharpsburg was really three battles. There were three separate Union assaults on the Confederate left (by Hooker's Corps in the early morning, by Mansfield's Corps around noon and by Sumner's Corps slightly thereafter). Each of these attacks by fresh Federal troops was straight south on the Sharpsburg-Hagerstown Rd. Each split the Confederate line and almost reached the Dunker Church. A slightly sunken country lane served the Confederates as a trench

and the dead and wounded here led to the name "Bloody Lane." Each attack was stopped by the Confederates.

In the center, a second separate attack in the early afternoon was stemmed by the Confederates.

On the Confederate right, a massive afternoon onslaught by Gen. Burnside was stopped only with the providential arrival of Gen. A. P. Hill's troops from Harper's Ferry; thus, the greatest carnage was on the Confederate left.

Letterman visited various hospitals. There was an acute shortage of medical supplies as well as of food for the wounded. There was also a shortage of ambulances. Most of the wounded were removed from the right side of the Federal battle line before two o'clock on the 18th and from the left, where no well-organized ambulance system existed, by the night of Sept. 18th. The number of Federal wounded was 8,350. Many of the wounded were removed to Frederick by ambulance. They halted at Middletown for food and rest. In addition to the hospitals in Frederick, two 1,000-bed tent hospitals were erected. One large hospital established in Frederick some months previously was already filled with Confederate sick and wounded who had been left there. Six buildings in the city were used as hospitals, and contained 2,321 patients on Sept. 30th; 62 surgeons, 15 medical cadets, 22 hospital stewards, 539 nurses and 127 cooks were on duty.

All Confederate wounded were removed as rapidly as recovery would permit. Surgeon J. H. Ranch, USA, was assigned to administer medical care and removal and direction of Confederate medical officers who had been left to look after their wounded.

A great many civilians came to the hospitals attempting to remove their relatives to homes. Letterman was convinced those taken care of in barns did better than those in houses, whereas those taken care of in the open did better than those cared for in barns.

Some writers have labeled surgery on the battlefields as butchery. Letterman's opinion was that surgery was probably too conservative.

As a result of the experience from the battle, a new system of medical transport and a clearer definition of the surgeon's responsibilities was inaugurated on Oct. 4, 1862.

Sharpsburg (Sept. 17, 1862) At the Front

A number of Union official reports are available⁴ tracing the medical activities from the field at Sharpsburg to the general hospital.

Asst. Surgeon John T. Reily, of Gen. Franklin's Corps, was assigned to the extreme right of the Federal line on Sept. 17th. The field was literally covered with killed and wounded, and it was extremely difficult to move on horseback without injuring the wounded. The confusion of getting troops into position prevented removal of the wounded, and they were under fire for several hours. Most of the wounded were removed to hospitals by night. "The night was occupied in dressing wounds, arresting hemorrhage and preparing for oper-

ations." On the afternoon of Sept. 18th, wounded were removed under a flag of truce.⁴

Asst. Surgeon A.A. Woodhull reports that he was on duty on the field. The wounded were brought on stretchers to him and ambulances carried them a couple of miles to the field hospital. A few primary operations under chloroform were performed prior to going to the hospital.⁴

Surgeon C.F.H. Campbell reported "The carnage was fearful among the rebel troops on the right . . . our casualties consisted mainly of wounded, the majority of whom were shot in the lower extremities or from the waist down, the reverse being the case among the rebel wounded."

Campbell was assigned to duty in Frederick as Medical Director of Transportation of Sick and Wounded. The wounded were sent to Washington, Baltimore and Philadelphia; 1,356 were sent to Baltimore, transported by freight cars, the bottom of the cars being covered with straw or hay. One train of cars carried as many as 1,200 patients.⁴

In a Hospital

("A hospital alone shows what war is."—Erich Maria Remarque, author of *All Quiet on the Western Front*.)

The following letter written in Sharpsburg by Daniel Ford, SJ to Frederick Home Hack shortly after the battle, gives an insight into a hospital overwhelmed by wounded:⁵

Ah me! How heartily I wished, while passing through these aisles of misery's temple, that I might have you at my side. I longed for you at every step; for here is war stripped in these smashed limbs, these amputated members, these horrible disfigurements, this offensive stench, these agonizing deaths, these ravings and these groans. Here battle is no longer decked in the tinsel glow of glory and honor which the devil in all ages has succeeded in flinging over it by means of his faithful ministers, the poets and romancists and historians. And if sights and sounds like these could not sicken you of war, and divorce you from the blind ambition that has fooled many an older head than yours, then you are beyond anything I might do for you. I found one man with the upper front of the skull shot off, so that if he were to lean forward, the brains would fall out. Another in half-delirium, despite my controlling efforts, tore off the dressing of his wound even to the lint, that he might show me the gash and rot in his hip where the minnieball was still buried. A poor young "reb" aroused my special sympathies. He was evidently unused to suffering. He complained of everything. He could not drink tea, and did not know what the soup was made of. (At the moment, I saw him fishing up a large shred of chicken from his bonilli.) His ankle had been shot through and through, and he was awaiting amputation, only doubting how far up it would take place. I asked him what he would like, and he said "Almost anything, but I can't drink tea." I thought of my boy, but I saw a thousand: What can I tell you of them all? The case that horrified me most was that of a Georgia captain. He lay as placid as the dead. His left eye was shot away. Dr. Smith told me that the poor fellow had actually torn out the ball from the wound with his own hand. Now he was lying so still that the surgeon began by trying if life yet lingered, but when the hands engaged in removing the bandages approached the wound, the speechless mass of flesh writhed and agonized unutterably. I pressed forward to hold his hands, but I was obliged to yield my place to one more accustomed to the horrors of war. The patient has since died in tortures of locked-jaw, grinding curses and blasphemies from his clenched teeth.

I interrupted my letter to visit the hospital again, and offer to God's representatives the little service within my power. "In-

asmuch as ye have done it unto the least of these, ye have done it unto Me."

The last hour has been spent in a mission yet sadder, if possible. A young man is to be hanged here tomorrow, and I have just left his cell. His crime is the murder of a woman and child. You may well believe that it roused strong emotions in me to find myself talking with a being in perfect health, whose death at a fixed hour tomorrow is as certain as any event of human ordering. He seems about 22, is about 5'5" tall, is very well-knit and talks freely. His eye is dark brown, his mouth cool and firm, but not vicious; his whole face is colorless though full and is overspread with an expression of coldness. I don't think he has ever known how to cry. His hand is cold, and so are the lips which I pressed at leaving him. God pity him! He asked me to be with him tomorrow, but our Fathers, through whose efforts he has become a Catholic, will attend him. Within a day he will be thrust into eternity. May God give him strength and consolation to the end.⁵

Gettysburg

This battle lasted over three days (July 1-3, 1863) with a total of 43,500 casualties. As at Sharpsburg, the Confederates retreated, leaving their dead and wounded in their own or Union hospitals.

The story of the wounding and evacuation of a member of the 2nd Maryland Infantry gives a vivid picture of the evacuation of the Confederate wounded from Gettysburg. John Goldsborough White from Talbot County wrote these reminiscences some 60 years after the battle, using his diary as a basis. This abstract starts July 2nd, the second day of the Battle of Gettysburg:⁶

Calm Before the Storm

I slept like a log. We were out in the open field, and I can remember that we boys felt that we got more fresh air, and had a more comfortable night than the fellows who had gone into the cover of the woods. July 2nd, the sun rose clear and bright, but in a short time there seemed to come a dark cloud over the sun. I can remember how the cloud over the sun (it must have been smoke from the first day's battle) gave the Confederate division flag the appearance of having been all smoked up and dipped in blood. Then it cleared up and the sun was shining again. All was very quiet, each side facing the other, and thinking of what was to come.

Before eight o'clock the skirmishers had gotten into action, and cannon from both sides, the enemy on the slopes of Culp's Hill and our cannon on the elevations beyond us, to the left of where we lay waiting. All the forenoon and until three in the afternoon, we lay there, as near as possible under cover, watching the artillery in action on our side of Cemetery Ridge, and witnessing the fearful explosion of shells which Gen. Lee was directing into the enemy ranks from around on the other side of the enemy position.

At three o'clock in the afternoon, the order came for us to go forward. As far as we could see through the smoke, Stewart's Brigade moved forward as though on dress parade. Only for a little way, however, for soon we could hear the zip, zip and the whiz of the minnies; as they passed us we could detect it in the air. The first boy I saw struck was only a few feet from me. I know that he must have been killed outright. For all these years I have tried to locate in my mind who he was, but the excitement of the moment simply swept details of persons and incidents aside, and all that we could see was simply that we had to keep going at the enemy's position.

Officers Dismount

We knew that the enemy were giving ground, and that we were getting possession of the advantageous position that they had held in the woods and that we were driving them back across Rock Creek. An hour before sunset, we were at Rock Creek; it must have taken us considerable time to get across. It was not yet sunset when our line was formed on the enemy side of the

creek. The whole regimental staff of officers dismounted, and on foot with the common soldiers, Lt. Col. James R. Herbert, with two pistols strapped about his waist and waving his sword, took a position about 10 yards in advance of the line. All officers' mounts were sent to the rear, and we started on again.

We moved a considerable distance, the shells and the Minnies coming thick and fast. I can remember that we began the ascent of a very rough and timbered sort of little mountainside and that there were no end of huge projecting rocks, very steep in places. Jim Dorsey and I were out in the open, where we both halted for the purpose of reloading; we tore the paper on our cartridges with our teeth: He cried out to me, "Did not that ball strike you?" I don't know what I said, but I did not move. When I did move, down I went in a heap on the ground. It did not hurt a bit; just seemed to deaden the foot and leg. Then I remember Dorsey saying, "You had better get away from here, and try and get back." I told him to "Go on," that I "Couldn't move." For some time I lay there nursing the leg; it was well after darkness when litter bearers got me across Rock Creek.

Used Gun as Crutch

Many badly-wounded were being brought across the creek. I remember that I brought my musket along with me on the litter, and that I told the fellows there on the bank of the creek that I thought I could make it further back using the gun as a crutch. It must have been near midnight when I hobbled into the field hospital. Lanterns were burning, and I sat down on the ground and got my shoe off. The bullet had entered my foot directly on top of the instep. My foot was so saturated with blood that I did not know whether the bullet had passed out of the bottom of my shoe. The doctor wanted to know "If the bullet was still in there?" I told him that "I did not think it was." He ran an instrument into the wound and shook the bullet around among the crushed bones of the foot, and wanted to know if I wanted "A drink of whisky." My reply was "For him to go ahead—that I wanted to see what he was going to do." I can remember the slashing open of the flesh, and then the forceps pulling loose the bullet from the wedged-in location in the bone of the instep; the most fearful pain that I have ever known.

I lay on the ground outside the hospital tent the few remaining hours of the night. With daylight, I remember that the first man I saw of my acquaintance was poor old Tom Edgar, my boyhood friend and childhood acquaintance from Talbot County, a member of our company. He was just alive. I hobbled over to where he lay and took his head in my lap and asked him how he felt. He told me that the surgeon had told him that he could not live. He did not seem to be in pain. The ball had gone into his left side and pierced one of his lungs or some vital spot. Soon Bill Hardcastle (one of the boys who had come from Talbot County with me) came along. He had brought in some of the badly wounded.

Death Tolls High

I asked Hardcastle what he knew of the regiment, how it had come out in the matter of casualties, and he replied that the 2nd Maryland was almost wiped out; that Col. Herbert was fearfully wounded, shot three times; that Maj. Goldsborough was also badly wounded, pierced by two bullets, and with tears streaming down his face, he said that Capt. William H. Murray, of Company A had been killed outright. All of the right of Murray's company and the left of ours (Company C) were killed or wounded.

I wanted to know of Hardcastle as to where the remnant of the regiment was at this time (it must have been around 9 AM). He seemed surprised in my not knowing what had happened, and pointed in the direction of the brow of Cemetery Ridge and Culp's Hill, exclaiming, "They are up there, we drove them out and are holding the position; the whole of Johnson's division is up there, what's left of it." Later I was to know that the 2nd Maryland Infantry had carried 500 men into action, and that over 300 of us had been either killed or wounded.

Wounded Removed

While the fearful noise of the artillery duel taking place on the other side of Cemetery Ridge was at its worst, all of our

wounded were removed further back. I remember that I was half lifted and half assisted myself into a covered Army wagon, where others much worse off than myself were lying or seated on the floor. I have a decided recollection of Col. Bradley T. Johnson being present and assisting in the arrangements for getting the wounded away from the field hospital. He had arrived on the field of battle about 10 o'clock that morning, having left Richmond a few days prior to the Battle of Gettysburg and ridden all the way on horseback from Charlottesville, hoping that he would be with the 2nd Maryland before the two armies would clash. From this time on, he was to be in active command of that Division, or remnant of Maryland troops, known in Civil War history as the Maryland Line. Later, he was to be advanced to Brigadier General.

I have a distinct recollection of the quiet which prevailed when the artillery fire ceased just preceding Pickett's charge. The Army wagons had removed us to some small crossroads village, and all of us knew what the pause in the artillery fire meant—that Gen. Lee was sending his infantry against the opposite side of Cemetery Ridge.

When night came on, we sensed that the attempt to crush the enemy had not been a success. The wounded were again loaded into the wagons and a long train of Army ambulances started in the direction of the town of Gettysburg. I can remember how surprised we were that the enemy were nowhere in evidence and that no interference was made in our going or proceeding in the complete half-circle which it was necessary for us to make in reaching the rear of Gen. Lee's position. I have been upon the roads we traveled that night since the close of the war and from what I would judge, we were carried a distance of over 10 miles and the better part of the remnants of Gen. Ewell's Corps covered that distance in the line of retreat through Gettysburg and on to the rear of the main Southern Army. This I have always thought one of the greatest accomplishments of the Civil War. The failure of the enemy to interfere with our line of retreat completely around their entire left was the best indication of the demoralized condition of Gen. Meade's Army.

Swollen River Barrier

The wagon procession in which I was traveling made no stop until we arrived at Williamsport, on the Potomac River. I can remember that, counting the night we started, until we reached the river, we were two nights and one day on the road. When we got to the Potomac, it was so high from heavy rains that it was out of the question our attempting to cross. Where we stopped, the river banks were very high; our wagons halted on the very brink of the steep, rough river side. The driver of our wagon was a husky, good-hearted North Carolinian, and soon after our arrival at the river bank, he suggested that those of us who were able to crawl around get out of the wagon and seek safety under the brink of the river bank, where we would be protected from the cannon fire of the enemy. The driver used his wagon shovel to dig me a sort of pocket under the bank, which was my bunk and living quarters for almost a full week, as we lay there watching the rushing, muddy waters of the Potomac gradually fall.

While there on the river bank, I got a pencil and some paper and wrote a letter to my mother, telling her that I was still alive, and that from reports I had gotten we believed Maj. Goldsborough would live. I told her of Capt. Murray's death and of poor old Tom Edgar dying with his head resting in my lap. This letter my North Carolina friend left with some of the citizens of the community where we were halted, and when the war was over years later, I saw it in my home in Talbot County.

Aided Across River

Before the river had fallen sufficiently for the wagons to cross, the mounted soldiers were swimming their horses over to the other bank, and a ferry boat was in operation, which carried many of the wounded over. A cavalryman suggested one morning that he boost me onto his horse so that I could ride to the boat. I got across safely, and in about a half-hour the cavalry soldier got across and assisted me in dismounting. A fierce artillery battle was going on the morning that I got across the river, and

the shells were bursting in all directions, our position on the southern side of the river being much more exposed to the fire than we had been under the bank on the enemy side.

I can remember that the wagons got us into Martinsburg on a bright Sunday morning. There must have been some in the line of march whose spirits were still unbroken, or it may have been that the bands with the infantry divisions wished to cheer up the wounded, as the bands were playing "Carry Me Back to Old Virginny" when we got into town that morning. My foot had not been dressed or treated by a doctor since the night of July 2nd, and was as black as a hat. I had it dressed at Martinsburg, and was given a pair of crutches. Bob Clough, one of the boys who had tramped with me from Talbot County to Richmond, arrived in Martinsburg while I was there. He was badly shot in his left arm. From Martinsburg we were sent to Lee Town in Jefferson County, VA, where we were kept for several days.

While at Martinsburg, I ran onto my haversack with the Yankee shirt and underclothes change which I had grabbed off when we licked Milroy, and was able to make a full change. Believe me, the change was needed, as I had been wearing the same clothes since we had marched away from Winchester on our way to Pennsylvania! The old clothes, dirty, black from the mud and the grime of battle, were thrown away.

Aided by Farmer

A farmer living in the vicinity of Lee Town (I have wished so many times that I could remember his name), volunteered to use his farm wagon for conveying a bunch of us wounded to some point further south. We started on our ride, winding up 150 miles away, at Staunton. A long ride over the old Valley pike, a ride which comes up fresh in my memory over all these past 60 years or more. We were about a week in making the trip.

At Staunton, arrangements were ready for our transfer by railroad to a Richmond hospital. I remember when we got to Charlottesville that one of our wounded was insistent that I leave the train there and go with him to his home near by, but the officer in charge of us objected to my doing so, and, on the first day of August, 1863, I found myself in Chimborazo Hospital, in Richmond.

One of the surgeons in charge was a fine young fellow from Georgia, named Carlton, and another, Dr. Washington, a Virginian, who had been stationed at St. Timothy's School when I was there, and a third surgeon was Dr. Bowen, a fine old gentleman. He was from near Manassas, VA, and since I have made my home in Prince William County, VA, I have come to know of the fine qualities of that old gentleman. Dr. Bowen often brought his pretty daughter with him to visit us while we were in the hospital.

In Critical Shape

My foot was in a fearful condition. The surgeons informed me that I was lucky to be alive after having gone so long without proper treatment, the crushed and broken bones of the arch of my foot. Broken and smashed pieces of bone worked gradually out of the surface. I tried to save each piece of bone, with the bullet, which the doctor had given me at Gettysburg. I had them tied up in a handkerchief and think I managed to hold on to them until I lost the whole outfit in the Cold Harbor fight in 1864. Dr. Carlton put me in a tent out in the yard of the hospital, and the open air quarters did me good. I remember that I stayed in the tent until the cold weather had set in.

White's account of his wounding and evacuation shows the total inadequacy of the Confederate ambulance, evacuation and hospital system.

Gettysburg: Dispersal of the Wounded

The major problem in dispersing the wounded following the Battle of Gettysburg was interference with railroad transportation. Railroad bridges were knocked out by Rebel raids, after these were rebuilt, some were washed away by floods. Patients were sent by train to New York, Baltimore and York. Every train of wound-

ed was placed in the charge of a medical officer, who was given instruments, dressings and stimulants. Each car was filled with a sufficient quantity of hay, water coolers, tin cups, bedpans and urinals. The Sanitary Commission was very helpful in feeding and attending the patients. "At Baltimore, the agents of several benevolent societies distributed food bountifully to the wounded in the cars immediately on their arrival."⁴

There is a charming account of the vicissitude of the people of Carroll County during the Civil War, drawn from personal reminiscences and newspaper accounts.⁷ During and following Gettysburg (July 1-3, 1863), the wounded of both armies drifted south through Westminster. A hospital was set up in the old Union Church, and wounded were evacuated by the Western Maryland Railroad to Baltimore. Many wounded were taken into private homes. Members of the Adams Express Company of Baltimore organized a volunteer hospital corps with proper supplies, men and spring wagons to bring out the wounded. The local coffin-makers were put to work and the dead were buried in local cemeteries. On one occasion (the skirmish of June 29, 1863 at Westminster) two Union soldiers and two Confederates were killed and buried from Ascension Church at Westminster. The two Union men were buried together in the same grave, as were the two Confederates.

Monocacy

Like the other two invasions of Maryland (Sharpsburg, 1862 and Gettysburg, 1863), Jubal Early's invasion in June and July of 1864 was a daring gamble that the presence of Confederate troops in the heartland of the Union could bring the North to sue for peace. An additional purpose was to draw Union troops from Richmond to defend Washington, and thereby lessen the pressure on Lee's Army of Northern Virginia.

Early, having defeated Hunter near Lynchburg, rapidly advanced up the Shenandoah Valley, (June 27-July 4, 1864), crossed the Potomac at Shepherdstown (July 5th) and advanced eastward. On July 9th, a hastily-gathered Union Army of 5,850 men met Early's army of about 15,000 on Monocacy Creek, just south of Frederick. Although eventually overwhelmed, Wallace's Union forces delayed Early and further exhausted his army. Two days later, Early's tired army reached the northwest outskirts of Washington. By this time, new Federal troops were streaming into Washington at the other end of the city, and Early subsequently retired.

At the battle on July 9th, the Federal losses were 130 killed and 560 wounded; the Confederate losses were 250 killed and 650 wounded. Several days later, 435 of the Confederate wounded were in country houses or Frederick hospitals when Federal cavalry reoccupied Frederick.

The major part of the battle took place on the Worthington Farm. During the battle, the family took refuge in the cellar. Glenn Worthington, then a young boy, wrote of the wounded:⁸

"After the battle, the dead and many wounded lay over fields where, as soldiers militant, they fought and fell. There were dead and wounded on the Worthington farm, in the cornfield, in the pasture field, in the wheatfield and in the yard and gar-

den; and on the Thomas farm in almost every field as well as about his house, yard and premises; down by Gambrell's Mill, there were others who gave their lives or suffered grievous wounds, fighting for the cause they deemed to be just.

"Where the peaceful harvesters had, but a few days before, cut and gathered into stacks the ripened grain, there on this day was the harvest of death and the blood of heroes on both sides stained the stubble and the straw of the bound grain, and the bodies of the dead and wounded were mingled with the scattered sheaves.

"In some fields, the dry wheat stubble caught fire and burned over wide areas, threatening to envelop the helpless wounded who lay there, but friendly hands with blankets beat out the spreading flames. One wounded Rebel stated that a Yankee beat out the flames close to him and thus saved him from the torture of being burned to death. A wounded and helpless foe is no longer an enemy. Such deeds of mercy and humanity are not infrequent in war, it is said, thanks to our better nature and Christian nurture.

"One who was in the battle thus writes:⁸

'I pass a comrade sitting by the roadside. Blood is trickling from a wound just below the heart . . . I say, "Goodbye," to him; there is no regret or fear in his tone as he replies. A brave country boy he had lived, and death has no terrors for him. He could not have smiled more sweetly had he been lying down to pleasant dreams.'

'Hours afterward, I carry a canteen full of water to another comrade lying on a pile of grain in the storehouse by the railroad, and he, too, had no complaints or repinings. He only said, "I have my death wound," and with the dew of youth yet fresh upon him, with all the prospects of a long life ended, he closed his eyes in dreamless sleep.'

"After the battle, dead and wounded lay around and about the Worthington house, some wounded screaming with pain, some groaning in agony, others enduring silently. One large Confederate lay bleeding in the backyard, in the angle made by the wings of the house. He was shot several times and was mortally wounded. He died within the hour. Mrs. Worthington spoke to him shortly before his death and inquired, and he replied saying that he had a wife and children at home.

"Another, a soldier in blue, had a bullet wound in his body that caused him to bleed internally. His abdomen was discolored from the internal hemorrhage. He was propped against a tree in the front yard of the Worthington House, and his groans were pitiable. A Confederate surgeon at Mr. Worthington's request gave him morphia to deaden his pain. He died during the night. Many others were brought in on stretchers, some to be treated, some to be buried. Hospitals were also established at the McKinney home, at the Thomas house, at Gambrell's Mill and along the highway near the Yaste house; and so they died, the young and the old, on the field amidst the roar of cannon and musketry, in the hospitals of wounds, on the picket line, anywhere, those who wore the blue and those who wore the gray. They deemed the cause worthy the sacrifice. God give them rest and a rich reward."

Military Hospitals in Maryland

In September, 1861, W. A. Hammond established the National Hospital in Baltimore. Located conveniently near the B. and O. Depot, 600 yards from the harbor, it consisted of a large piano factory and 11 dwellings on both sides of Camden St. It was five stories high. There were 15 wards. The leakage of water into the cellar required continuous pumping and, because of the low ground, there was defective drainage. The buildings were all brick and were heated by furnaces, by wood fires and by open fireplaces. Ventilation was maintained by transoms. Water was supplied from street mains and distributed in lead pipes. There were 10 water closets for the whole hospital. The hospital contained 700 beds, each patient had 800 cubic feet of space. The average daily census was 450

people. A second hospital called West's Buildings, consisted of six warehouses of three stories, each of which contained 400 beds, four bathrooms and water closets. It was heated poorly by coal stoves. A third Maryland hospital was McKim's Mansion in Baltimore. This was originally a barracks built around the McKim Mansion for temporary shelter for troops. It had a poor water supply, was poorly-constructed and had no water closet.

Patterson Park Hospital in Baltimore was another hospital converted from barracks in April, 1862. There were 17 wards with 426 beds.

The Hammond Hospital at Point Lookout, MD between the Chesapeake Bay and Potomac River was located on a low, narrow peninsula, a former summer hotel. It was difficult for steamers to dock. It was in an isolated area. In 1862, a plan for a special building on the pavilion system was started, but was incomplete by May, 1863.

Probably the best-constructed Union hospital during the war was the Hick's Hospital in Baltimore, opened in January, 1865 in the western section of the city, but the war ended before it was completed.

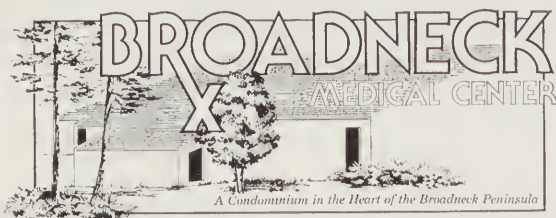
The Jarvis General Hospital was the largest of six hospitals in Baltimore. It had 1,500 beds and was built on the property of Maj. Gen. George H. Stuart between Mount and Monroe Sts. on West Baltimore St. It was opened June 20, 1862.

George Perkins, in his book *A Summer in Maryland and Virginia*, tells us what happened to patients when they arrived at a hospital. He arrived at the Tent Hospital in Annapolis in 1864. All clothes were taken and burned, then each patient had a close haircut, a hose was turned on each person and a good scrubbing was administered and nightgowns were issued.

We have an interesting description of life in the Jarvis General Hospital during 1863 and 1864.⁹ Mrs. Sarah S. Spear of Baltimore volunteered to work at the hospital. She notes that it had a good view of the harbor and horsecars passed within a few yards from its doors.

On July 22, 1863, she notes that since Gettysburg, two or three patients died daily in the Hospital. She was Officer of the Day for volunteers and distributed dinners and suppers for those not able to get to the dining room. There were about a thousand patients of whom about one half went to the dining room. One large section was filled with Confederate wounded. Funeral services were held under the trees. A service was read, one hymn was sung and one prayer was said.

Mrs. Spear participated in entertainment for the soldiers. She wrote letters for them to their families. She sung in a quartet, songs such as *Just Before the Battle, Mother and Who Will Care for Mother Now?* She washed out the Chapel every Saturday and played the melodium for the services. She notes that the patients preferred military titles in their reading. Books such as *Masked Batteries, A Greater Rebellion, Halt, The Grand Army* and poems such as *The Rainy Day in Camp* were very popular.



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Jarvis General was closed as a hospital Aug. 26, 1865; 17,000 patients had gone through the hospital.

Early in the war, soldiers were discharged without adequate planning. A letter from President Abraham Lincoln in October, 1862 follows:

"A Baltimore Committee called on me this morning, saying that the City is full of straggling soldiers, half sick, half well, who profess to have been turned from the hospital with no definite directions where to go. Is this true? Are men turned from the hospitals not knowing where to go? A. Lincoln."

A number of attempts had been made to start convalescent camps to permit patients not requiring hospitalization to recover. One was in Alexandria, Virginia and one on David's Island, NY. They were known as military depots and were used for stragglers, convalescents and nondescripts of all kinds.

In addition to the Army hospitals in Baltimore during the Civil War, the University Hospital was also used for wounded Union soldiers. The hospital made a profit on the soldiers in that they charged \$5. per week for a soldier, but only \$3. a week for a private patient. Although it was notorious that the sympathies of the Medical Faculty were blatantly Southern, their treatment of Union soldiers won high commendations from the Federal government.

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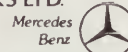


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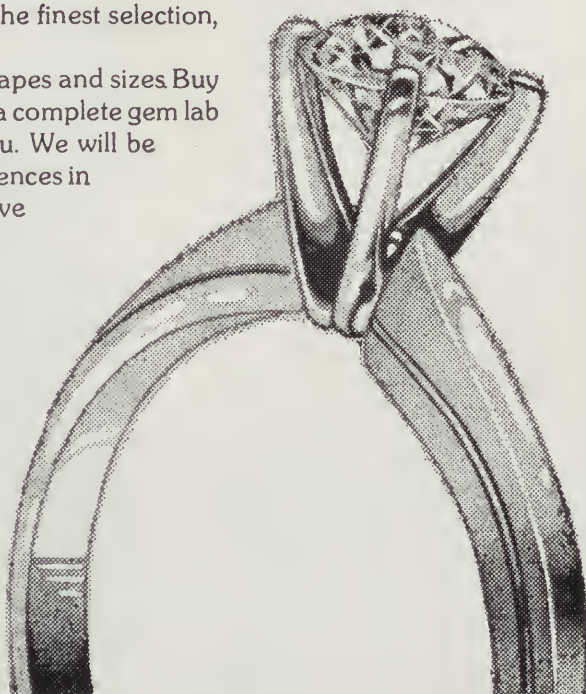
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Medical Hypnosis Versus Hypnotism: What They ARE—and What They Are NOT An Exclusive JOURNAL Interview With Edward O. Hunt, Jr., MD, PA

By BLAINE TAYLOR

Contact Mr. Taylor, JOURNAL Managing Editor, for reprint and other data to the JOURNAL, 1211 Cathedral St., Baltimore, MD 21201.

Hypnosis vs. Hypnotism

Dr. Edward O. Hunt, Jr., 42, has had, since 1968, a private practice of general and vascular surgery in Baltimore. Named Chief Physician of the Baltimore City Fire Department in 1978, the tall, muscular, friendly, mild-mannered and soft-spoken physician is also one of only four Board-Certified Medical Hypnotists in the Baltimore metropolitan area. As a diplomate of the American Board of Medical Hypnosis, (he was elected in 1978 to its Board of Directors also) which—as he was at pains to point out again and again during this exclusive JOURNAL interview conducted on May 7, 1979 in his Garwyn Medical Center office (where he maintains what he believes is one of the area's first, non-group, computerized practices)—is not the same as a word he sparages: "hypnotism."

Born Apr. 6, 1937, the Baltimore native graduated from Dunbar High School in 1954 and Capital University in Columbus, OH four years later. After graduating from the University of Maryland Medical School (where he was only the eighth black admitted) in 1962, Dr. Hunt went a one-year Internship, and a Surgical Residency the following year, at Sinai Hospital.

Between 1964-67, he served a Surgical Residency at the Veterans Administration Hospital at Perry Point, MD, followed by a Chief Surgical Residency stint at Baltimore's VA Hospital. His current hospital affiliations include Provident, Union Memorial, Maryland General, Lutheran and North Charles General, all Baltimore.

After the death of his uncle, Dr. Richard Hunt, Dr. Edward Hunt became Principal Physician of two nursing homes in Glen Burnie, MD. Subsequently, he assumed Medical Directorships of nursing homes both there and in Baltimore. As a result of his involvement in long-term care, he became affiliated with the American Association of Nursing Home Physicians, and, in 1977, he was elected President of this Association.

In 1972, Dr. Hunt was accepted into Fellowship in the American College of Surgeons. He has been a member of numerous professional organizations, including the American College of Surgeons, the Monumental City Medical Society, the National Medical Society, the Baltimore City Medical Society and the American Society of Clinical Hypnosis. Dr. Hunt joined Med-Chi in 1970, where he served as a two-year member of the Emergency Services Committee.

During 1974-76, Dr. Hunt was President of the black ME-DE-SO (Medical-Dental Society) club. Between 1973-77, he was elected as a member of the Maryland Commission for Nursing, and was its Vice Chairman for two years.

He was chosen as a Fire Department physician in 1972, and is presently completing his third term as Secretary of the Baltimore City Professional Standards Review Organization (PSRO).

His published papers include *Awareness Under Anesthesia, Investigation of an Adult Duplexic Using Hypnosis* and others. A member of the YMCA, NAACP and other civic groups, Dr. Hunt and his wife, Ruth Brooks Hunt, have three children: Susan, 17 and twins

Mark and Monica, 14. Dr. Hunt's hobby is making model airplanes, ships and cars.

His active clinical interest in hypnosis began nine years ago. Since 1970, Dr. Hunt has attended numerous workshops and scientific and training sessions in the field of medical hypnosis, both as student and lecturer, and discussed at length with the JOURNAL—in his calm, patient and soothing voice—what he considers an important and growing (if rather unknown) area of medical practice today and in the future.

Introduction

What IS medical hypnotism? How many people practice it in the country? I want to try to give our readership a perspective concerning the scope of the subject.

Well, I try to be very careful with semantics in hypnosis and try not to use the word "hypnotism," because the word hypnotism invites thoughts of the occult, so I strictly say "medical hypnosis" instead.

Is hypnosis DIFFERENT from hypnotism?

Not really. They're two words that mean the same thing, historically. As for professional hypnosis societies—there are two in the country that're limited to MDs and PhDs—the first, the American Society of Clinical Hypnosis, has approximately 4,000 active members, while the second, the Society for Clinical and Experimental Hypnosis, has about 2,000.

What about the people who DON'T belong to EITHER of those two groups, but who're still in the field?

There are some people who have some training in hypnosis who don't belong to either Societies; however, in these Societies, we're carefully trying to keep hypnosis professional, therefore, we don't want to include professions that're not medically-oriented. There are some MDs and PhDs who don't belong to the groups I've mentioned, but who do belong to other groups that have professionals who aren't medical professionals.

I'm very careful to make this distinction because you can find some people—like a group which recently came to Bal-



DR. HUNT

further from Washington—to have weight-loss classes with hypnosis, and which, inadvertently, may encourage fadism.

Were they Mds or PhDs?

As far as I know, they weren't. Being non-professional in that way sort of degrades the aspect of hypnosis that we're interested in—and that's the part that's strictly used not for show, but only for professional purposes.

Is there that great a difference between the two?

If you're doing hypnosis on an individual, the hypnosis that is done for show, or religious purposes or weight-loss is the same; however, the difference for us is we feel that hypnosis is something that should be used as a part of the general medical treatment of an individual. Therefore, it's **not** used for show, and hardly ever do you see one of us in the professional societies giving demonstrations or other things that would present the showy, or "stage" aspect of hypnosis.

Weight-Loss and Control

CAN hypnosis be used in weight-loss or weight-control?

Yes.

Does it force the person to stop eating?

No.

How DOES it work?

There're different techniques. The one we like the least is the aversive technique, where you say "If you eat a potato, you'll have nausea and vomiting." What we'd prefer is a technique where suggestions are made that you really want to protect your body and you **are** your body's keeper. We like to get these suggestions to take hold in the person. Along with these suggestions are others of proper eating and diet if necessary. A successful individual will lose weight very well.

Over how long a period of time?

It varies. I suggest between two-four pounds a month.

New Laws Needed?

How do you stop, say, an unscrupulous weight-loss practitioner?

You can't.

There's **NO** way to protect the public?

No.

How does the law stop them?

It does not. We have, in some states, been trying very hard to get the laws changed, to have people who use hypnosis on medical conditions be physicians or psychologists or dentists. Those laws aren't available in some states.

What about in Maryland?

No.

Do you think they **SHOULD BE**, and would you recommend going to the General Assembly in Annapolis in January, 1980 when the next State legislative session opens proposing that something be put on the books?

Yes. Something **should** be done.

Is there, in your view, widespread abuse of medical hypnosis?

No, not in Maryland, but there is in some other states, such as California and Oregon. A number of the stage hypnotists seem to be there. I don't mind the stage hypnotists, as long as they don't suggest that what they're doing is useful medically. On the other hand, they've really given hypnosis a bad name!

Origins

Historically, how far back does medical hypnosis date?

Essentially from Franz Anton Mesmer, who lived during 1734-1815 in France.

Hypnosis Within the Medical Community

Do MDs who don't use hypnosis at all recognize it as a valid modality of medical treatment? Do they see it as viable and bonafide, or is it controversial?

All physicians don't have enough understanding of the basis and uses of hypnosis to be able to make such a distinction; however, the professional societies have been evaluated and reviewed by the AMA, the American Psychological Association and the American Dental Association. The medical, dental and psychological uses of hypnosis have been evaluated and accepted by all three, as does Med-Chi locally.

But **IS** it a controversial treatment mode, like acupuncture, that's still being debated?

I would feel that there are some in medical circles who aren't knowledgeable about hypnosis who **would** want to debate it, but those who've had input into it—either by training or exposure through professional use—acknowledge the fact that it is a bonafide adjunct to a patient's treatment.

How did you, personally, get into it and why?

I became interested in it during my third week of medical school at the University of Maryland in 1958, when my Professor of Psychiatry, Dr. Ephraim Lisansky, demonstrated its usefulness with some of the patients.

Does one get an extra degree to practice this? How does one become recognized as skilled in this area by his/her peers?

The training cycle that I went through was 1) beginning courses in medical hypnosis under the auspices of the American Society of Medical Hypnosis, followed by 2) advanced courses. 3) Then, I took the board examination. Later, I was asked to be a member of the Board.

Are the courses mostly demonstrative, wherein you're taught how to actually perform medical hypnosis?

That's correct. After you've taken the courses, you apply to the Society for membership and—after you've demon-

strated a certain amount of expertise—you move up to fellowship; the Board exams come after that.

What did the exam consist of? What **KINDS** of questions were there? What did you have to demonstrate?

The exam consisted of a written portion including multiple choice and essays. Then you had to sit before a committee and answer questions. Afterwards, you had to give a demonstration of your ability in hypnosis and had to present two recordings of case reports that you'd done plus being prepared to answer questions concerning them.

Is there any such thing as licensure in the medical hypnosis field?

No. People are recognized as bonafide practitioners by taking the courses and examinations I mentioned earlier.

Fees

Is there any kind of a fee schedule set-up for your services?

Yes. Hourly is best and, at present, I'm charging \$50 for an hour. This is a fairly standard fee, although a lot of people charge more.

Who determines what the standard and customary fees are?

The determination is usually made by the individual, based on the same hourly rate he or she would charge otherwise for consultative services.

Rasputin and the Tsarevitch

Are you familiar with the case of the Russian monk Rasputin and the Romanov Dynasty?

Yes.

There've been two rather good films made of this case history—the 1932 picture **RASPUTIN AND THE EMPRESS** and the 1967 remake from the book of the same title, **NICHOLAS AND ALEXANDRA**. In both of these films, Rasputin is pictured as hypnotizing the Russian heir to the throne, the Tsarevitch Alexei. Do you think those were accurate portrayals of what the monk actually did? Did he stop the Tsarevitch's hemophilia?

No.

I guess it's unfair to ask: What **DID** stop it? Supposedly, it **DID** work. It's shown the way I've described. Is it possible?

It is possible. It has been done in hemophiliacs to reduce the number of episodes of bleeding.

Is there a connection, then, between how the mind thinks and the body functions?

Yes, that's correct; however, you can't take one or two cases and say you can do it in every case. It will **not** be successful in every case. What some of the hematologist members of the Society are trying to do now is to define some laboratory parameters that would justify the occurrence, and that's something hard to do.

When Rasputin stopped the bleeding in the years before the Russian Revolution in 1917, it was considered a miracle. Is that kind of treatment given today?

Yes.

In large numbers?

No, in small numbers. I've seen—at some of the national meetings I've attended—maybe one person a year who'll present some hematological cases that include some people with hemophilia. I haven't had such a case, though. I have had people who've had normal blood clotting, who had a tooth pulled, experienced excessive bleeding and I've been able to stop it, usually within minutes. The dentists do it quite often.

Is this something that's done in the person's home or in your office or the hospital or anywhere?

Anywhere.

Methodology

HOW is it done? With a watch, as it's shown in the movies and on TV?

Years ago, you used watches, light and other moving objects. Presently, the most common form of hypnotic induction is a verbal or eye-fixation induction—just fixing the eye on some particular object. It gives a point of fixation as a beginning point for the induction of hypnosis, but we don't have any flashing lights—nothing like that. I can do it here in the office and in any of the exam rooms. When I have a patient in the hospital, I do it with the patient in the hospital bed, without interfering with the person in the next bed.

How long does it generally take you to put somebody under—if I'm using the correct terminology?

Less than 10 minutes. The older, previous hypnotists took quite a long time to get a person into a hypnotic trance, averaging three-eight hours.

What changed?

Improved techniques, a lot of experimentation and physicians reviewing each other's work. They got it down to one hour to a half-hour to 15 minutes; now, we can do it in anywhere between 3-10 minutes, easily. There're some patients who take longer, though.

Is it still the stereotypical thing wherein the hypnotist coos soothingly, "You're getting weary. Your eyelids are very heavy," etc.?

You can do it that way, but there're a number of other techniques of induction that aren't so stereotyped, and, in my practice, I use a lot of these other techniques of induction, simply because they're not stereotyped.

How many hypnotic trances do you perform in, say, a year—50? 10?

In one week, I might do two; next week, I might do 15.

Medical Problems Treated

What kinds of illnesses or conditions

can hypnosis be used in treating? We've already talked about hemophilia, for instance.

Hypnosis is most commonly-used in an office setting for anxiety and depressive reactions.

Can you talk somebody OUT of being anxious and depressed?

Yes. I can't say that they actually forget, but what they do is vary their response pattern, and I think that's what hypnosis does most.

Put that into simpler terms for me. Do you mean how they handle their problem?

Yes.

OK. So it gives them more tools with which to handle it?

Yes.

All right. Let's say someone doesn't have enough money to pay due bills. How would you handle the anxiety felt by that person?

Medical hypnosis isn't particularly useful for something like that.

How about a marital break-up, or alcoholism? Guilt feelings?

There's a number of different ways of approaching it. If your decision is to use a hypnotic trance for the approach, then you can approach it by what we call direct suggestion, and that's not necessarily the best. Direct suggestion means that you just suggest that, whatever the feeling or occurrence is, it goes away.

There're projective techniques wherein you can put a person into a trance and then suggest that they visualize things as if there were a play in front of their eyes on a stage. They can project themselves into one of the characters, and then make the character do something useful for that symptom. That person then accepts that suggestion as if it were their own.

Another technique which is particularly useful for chronic pain is to put a person into a hypnotic trance and then do a desensitization technique; that is, desensitize them so that the pain will be a little less at a certain point in time—a little less and a little less, as time goes on. Also, you can give them cues to assist the pain in diminishing or going away completely.

Is pain actually in the MIND and NOT in the physical body?

It's in both. Pain is physical, but the response pattern can be varied by the mind.

Can you talk someone OUT of having a heart attack?

No.

Can you make a person less nervous or tense whereby they'd be less susceptible to a heart attack?

Yes, but hypnosis cannot change organic symptoms at all.

Can it ARREST them to a degree?

If a person has appendicitis, you can ease their pain, but you can't stop their

appendicitis. They still have to be operated on for that appendix.

And the same would be true, then of the hemophilia we spoke of earlier? You could arrest the pain somewhat, but still have to deal with the condition in traditional medical modes.

Yes, that's correct.

The Hypnosis Decision-Making Process

Earlier, you mentioned a decision to use hypnosis in treatment. When do you make that decision, and what factors go into it?

In your medical practice, you learn right from the beginning to use different parameters of management of a patient. Hypnosis—like penicillin—is just one of those parameters. If I have a patient in my office who has a problem wherein hypnosis would be a useful parameter, and that person is responsive to hypnosis, then I'll use it.

How do you know—BEFORE using hypnosis—if a person is responsive or not? Can you tell BEFORE putting him or her under?

Yes. There're a lot of cues that we have. In fact, I use those cues to let me know whether or not it'll be worthless just to try it with a particular individual at this particular point in time.

What ARE some of the cues?

They're mainly responses to suggestion. If a person responds well to suggestion, then—usually—he or she will respond well to hypnosis.

How can you determine that BEFOREHAND, though, and, do you object to my terminology of "putting them under?"

I prefer saying "putting them in a hypnotic trance." There're a number of tests of hypnotizability that've been developed, and these can be used in both individual and group settings. Some of us use these tests to make our determination, but, also, one of the best ways is simply to put them into a hypnotic trance itself.

So, in essence, you have to DO it to see if you CAN do it?

But not completely, because there are some parameters that'll give you a pretty good idea—at somewhere about 80% accuracy.

Give me some examples, please, of some identifiable cues, parameters or indications. I think we're "shadow boxing" AROUND them, and I'm trying to get TO them—whatever they are.

When I said "An individual's response to suggestion," what I'm saying to myself is that, if I can ask a person to take a nice, deep breath, and that individual so responds, that is a good response to that suggestion. If the person's hesitant in that response, then he or she is not a good responder at that point in time to that suggestion.

At that point, is the person IN the trance?

No.

He or she is completely cognizant of what's going on?

Yes.

So, if I walked in right now off the street as your patient, we were sitting here talking and you were trying to sound me out, and you said, "Take a deep breath" and I did it without hesitation, THAT would be a step toward the possibility of my being put in a trance?

That's right.

If I didn't do it at all—and looked like an obstinate person—you WOULDNT do it?

Right. Now suppose I did this (at this point, Dr. Hunt stretched out his right hand toward me, and I shook it.—BT.) Your response was to do the same thing, so you are responsive to suggestion. If you had an individual who looked at you and did not respond, then you'd say to yourself "At this time, this person isn't responsive to suggestion." You then have two choices: either **don't** use suggestive techniques or allow the person to communicate with you better until he or she learns what you want them to do.

Another response to suggestion is, for instance, when you come into the doctor's office, you automatically **know** the doctor is going to take your pulse. What I can do is ask you "What is your response to that suggestion?" (As he said this, Dr. Hunt took my right arm and placed it in the air, where he left it suspended as he talked.—BT.)

That you're going to take my pulse?

No. Your response to that suggestion was that your arm stayed **exactly** where I left it! You see? Already, I've given you two tests! Another test that we use at present is what we call an "eye-roll" test. A person can look up and close their eyes and, characteristically, individuals will have a certain amount of the scleral or white part of their eyes visible as they close them, and it varies with individuals. We've found that the individuals who have **more** of the sclera visible as they do that eye-closure seem to be more responsive. We use other factors to go along with that, but if I have an individual who has a very good response to that test, I know that I can say to them, "Look, when we go into the operating room, we'll be able to use hypnosis for your operation," or for whatever it is.

Hypnosis and Surgery

How come you—as a surgeon—are into this? You're not a psychologist or psychiatrist. It would seem to me that hypnosis would fall much more into mental treatment, as opposed to something done with the surgeon's knife.

That's why—up to this time—so very few surgeons have been interested in it. Another reason is because of the old impression that it took so long to get a person into a trance, as I mentioned before. They feel they'll be wasting their time, and I felt that way at the beginning, too.

How do you use hypnosis in the operating room? Is it **IN PLACE** of anesthetics for pain or **IN ADDITION** to them?

Both.

All right. Give me an example of each—and then combine them. How would it be used in place of an anesthetic?

The one that would be the most outstanding example would be in the event that the patient needed an operative procedure and had had a previous poor response to anesthetics.

How many people reject anesthetics?

Less than 1%.

Does hypnosis help these people?

Yes, provided they're responsive to suggestion.

Hypnosis and "Faith Healing"

You may resent my analogy but, in a way, what you're saying seems to resemble "faith healing" which, as you know, is used for religious purposes.

Yes.

Do the faith healing ministers use a form of hypnosis or hypnotism in their public mass sessions?

They use similar suggestive techniques, and the individuals can go into a trance, but when we say "hypnotize people," what we're thinking of is making a defined beginning and ending point of the hypnotic trance. Most of those faith healers use suggestive techniques to the point where people go into their own trances, and, yet, they don't specifically know how to identify these beginning and ending points.

In other words, to get in and to get out of them?

Right.

Self-Hypnosis

Can people hypnotize themselves?

People always hypnotize themselves! I don't hypnotize **anybody**. What I do, essentially, is give them the cues to use their own capacity to go into their own trance.

Can they do it **WITHOUT** a second party?

Yes.

Have people known how to do it—and done it?

Yes.

Do they generally get out of it—or do they leave themselves in it and you find them a week later sitting somewhere in a trance?

You can time yourself almost exactly. I teach my students that they can go into their trance, tell themselves in advance that it's going to be two minutes and—usually somewhere around two minutes and 15 seconds—they'll come right out.

Where do you have your students?

At the national meetings and locally, too. Dr. Thurmond Mott has both beginning and advanced classes at the University of Maryland, and some of us assist him with those.

At what point in a doctor's training does he or she take these classes? In medical school?

Yes. During the junior year of medical school.

Does **EVERYBODY** get this training now?

No. Only selected people.

But everybody **COULD** if they wanted to?

Yes. It's in the curriculum of a number of medical schools now.

What is the name of the course?

Basic Medical Hypnosis.

How many hypnotists are now in Baltimore?

There's about 15 whom I know of from the national societies I mentioned earlier. With the classes, it would almost double that number if you get some of the students into the societies.

Dr. Hunt's Work

How would you rank yourself within those 15: an expert, lower or better than the others, or on par with them?

I am the best, non-psychiatric hypnotist in this area, and I can pretty much assure myself that I'm correct in that view. I **don't** do psychiatry at all, though. If I have a problem that appears to be psychiatric, and if I think hypnosis would be good for it, I send the patient to somebody like Dr. Mott, who is a psychiatrist.

OK. What kinds of surgical conditions CAN you treat with medical hypnosis?

The whole range of things! We've treated everything from sprains to lacerations to tumors.

WHY do you use hypnosis in a surgical setting—to control pain?

In surgery, if you use it for something like a sprain or a broken bone, you're using it for pain control, but if you're using it for a laceration, that's anesthesia. You can also use it for pain control in malignancies, where patients have chronic pain. As for surgical techniques, you can do operations inside the abdomen, take out the appendix, do intestinal or stomach operations, gallbladders, thyroid conditions, etc.

I've been very careful—and this is one of the reasons some people haven't heard of me—in trying to assure myself and others that this doesn't become just a stage procedure, as I related earlier, and when I use hypnosis in a hospital, I try not to let the people in the hospital or operating room feel that we're doing anything **different**. In the hospital, I request and advise my anesthetist in advance. If it's the proper procedure, the anesthetist is on stand-by. If the anesthetist wants to participate in any way, he or she may. When I use it in the operating room therefore, there's no "show" if at all possible.

Do you do it prior to the patient being wheeled into the operating room?

The hypnotic trance is fascinating in that, if a person can go into a hypnotic trance **once**—and he or she knows how to do it—they can get into it **anytime**. All I have to do is give them a cue to repeat their previous session, so, if I'm using it in the operating room and have hypnotized that person previously, all we—the patient and I—have to do is use the cue we've set up. I've put all of my children into a trance, because once a person has done it, as I said, he or she can do it. I'm fairly confident that, if my son breaks a leg, I can put him right back into a trance so that he can be comfortable while his leg is being set, but that's as far as I've gone with it in my family.

Can the cue of which you were speaking be only one word?

Yes, like "apple." On the other hand, if it's the first time—and we just happen to be in the operating room at the time—the suggestions that I give to induce a trance are similar to the suggestions the anesthesiologist would give anyway, if the anesthesiologist is knowledgeable in suggestive techniques. When I've used it in the operating room, very seldom have we put it on the operative schedule, as hypnosis or anesthesia or maybe we've put it on the schedule as anesthesia stand-by for local anesthesia, and just let the individuals who're in the operating room at the time know that we're using it. I've used it at Lutheran, Union Memorial, Maryland General and Provident Hospitals in Baltimore for surgery.

If you put a patient in a trance in an operating room, would it be possible for you to look up from the table and see everyone ELSE in the room, aside from yourself, ALSO in trances?

No. That doesn't happen.

Hypnosis and Behavior

Is it true—as one often sees in the movies and on TV—that the person hypnotized is completely in the power of the hypnotist, and can be made to jump out of a window, kill somebody or whatever?

A person who is in a hypnotic trance will not do anything that he or she couldn't do **OUTSIDE** of it.

So, if they murdered someone while in a trance, it really means they had murdered them to begin with?

That's correct.

And, conversely, if not, you can't FORCE a person to murder?

That's correct.

Mass Suggestion

I don't know if you've even seen films of the "Beatlemania" craze of the mid-1960s, which I've always felt was somewhat similar to the Elvis Presley fever of the 1950s.

Yes, I'm aware of these things.

IS there such a thing as a mass of people being hypnotized as a group by someone like Mike Jagger of the Rolling Stones?

That would really be mass suggestion, like TV advertisements, but I like to limit hypnosis to something, again, that has definite beginning and ending parameters.

With mass suggestion, what you're doing is inviting individuals to go into their **own** trance. The period of time isn't begun strictly by your starting point in time, but by the point in time in which they—the masses—have developed their trance.

Sirhan a "Manchurian Candidate?"

In the book and, later, movie, entitled THE MANCHURIAN CANDIDATE, a fictional person is programmed to commit several acts of murder.

That's correct.

Many people feel that this, indeed, is what DID happen in the case of Sirhan Sirhan, the man who assassinated Senator Robert F. Kennedy in 1968. Do you think that that's at all possible?

Yes, I do think it's possible.

OK, but how do you juxtapose THAT feeling with your earlier-stated belief that a person WON'T do it unless it's within him or her to begin with? WAS Sirhan ALREADY a latent murderer? To anyone's knowledge, he'd never killed anyone before.

In order to do that, you had to use a technique that's not within the realm of medical hypnosis, and those techniques—although they're highly-developed—and do use some suggestion, are **outside** the realm.

From what you've read of the Sirhan case, do you think he was hypnotized by someone? Throughout his diary—which was later found by the Los Angeles Police—Sirhan had written "RFK must die. Robert F. Kennedy must die," and on and on, time after time.

The answer to that would be no.

Why not?

Because that is a type of brain-washing that's included in the various sects where they use things such as mind-deprivation, physical-deprivation, torture, etc. Mind-deprivation is where you take an individual and either force him to stay in a position where he has limited sensory input and then you add to that an input that you want, such as a constant chant—and that's definitely outside the realm of medical hypnosis.

Hypnosis in Criminology?

Do you think a criminal's pattern of behavior can be changed through hypnosis?

Yes.

You could stop a murderer from murdering?

No.

Why not?

I said I could change his or her pattern of behavior, but if a situation occurred

in the future and they wanted to commit murder, that wouldn't stop them.

But it might PREVENT them?

Yes.

Another Role for Dr. Hunt

Let's talk about your work as Chief Physician of the Baltimore City Fire Department. What does a Fire Department physician do?

There're eight of us. We do two things: 1) take care of the minor illnesses of Fire Department personnel in an infirmary situation and 2) supply medical expertise at the scene of a fire. There's 2,200 personnel to care for.

Do you give them their preemployment physical exams?

No. That's done through the Civil Service.

Do you have regular hours of duty or are you on-call?

We have infirmary hours daily and a physician is also on-call each day. The infirmary is located at 1100 Hillen Rd. in Baltimore in the Oldtown Fire Station.

How did you get involved in this work?

I treated a fireman for about a year for a severe burn—over 87% of his body—and, the next time an opening came in the Department, I applied for it and was accepted. Incidentally, with the burnt fireman, I used hypnosis for pain control, and it worked beautifully—particularly with his dressing changes—and it also allowed us to reduce his dosage of medication. When his period of depression occurred, we used it again. It was a pleasure to work with him, but was mainly a learning experience for me.

He credited you with saving his life both physically and mentally, didn't he?

Yes.

Thank you, Dr. Hunt.

Acknowledgements

The author thanks Mrs. Mildred Chronister for secretarial services, as well as Dr. Hunt's able, cheerful and helpful secretaries, Ms. Katie Grove and Ms. Truemenda Mobley. □

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Meckel's Diverticulum: A Five-Year Study of 58 Cases at St. Joseph Hospital

By HON. K. POON, MD

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Introduction

Meckel's diverticulum, an embryonic remnant of the partially-unobliterated omphalomesenteric duct which bears the name of Meckel who described it in 1812¹ was actually first mentioned in the literature by Hildanus² as early as 1598. Though in itself not a common entity, the accepted overall incidence in the general population being around 2% as estimated in the works of many investigators,³⁻⁶ it is by far the commonest of all congenital gastrointestinal anomalies.⁷

The fact that it can present from its symptomatic group where it appears in the form of various intraabdominal diseases to its asymptomatic counterpart only to be found during laparotomy for other unrelated causes or during autopsy makes it a frequently-discussed topic in the literature. The following is a retrospective study of 58 cases in St. Joseph Hospital in Baltimore during the period of July, 1970-June, 1975.

Observation

During the five year period from July 1, 1970-June 30, 1975, a total of 58 cases of proven Meckel's diverticulum was recorded. All these cases were encountered either during laparotomy for various causes including symptomatic Meckel's diverticulum or during autopsy and all has histological diagnosis compatible with the anomaly.

Incidence

Among the 58 cases described, 44 were incidental in which the patients were asymptomatic, whereas 14 others were symptomatic. Among the 44 incidental cases, 35 were found during laparotomies for unrelated causes and nine were found during autopsy. All these nine patients died from other disorders unrelated to the Meckel's diverticuli. In the period of time studied, the total number of laparotomy done was 8,015 (All laparotomies including gynecological except C-sections.) Among all these laparotomies Meckel's diverticuli was found in 49 cases, 35 of which were "normal," while the rest (14) were diseased (Table 1.) A summary of the distribution of the total 58 cases is presented in Figure 1.

Age and Sex Distribution

The 58 cases of Meckel's diverticulum included 35 males and 23 females. The youngest case was found in a seven-month-

TOTAL # LAPAROTOMY	8,015	100 %
TOTAL # OF MECKEL'S DIVERTICULUM FOUND DURING LAPAROTOMY	49	0.61 %
INCIDENTAL	35	0.43 %
DISEASED	14	0.18 %

TABLE 1:

Incidence of Meckel's diverticulum, diseased and incidental, in present series.

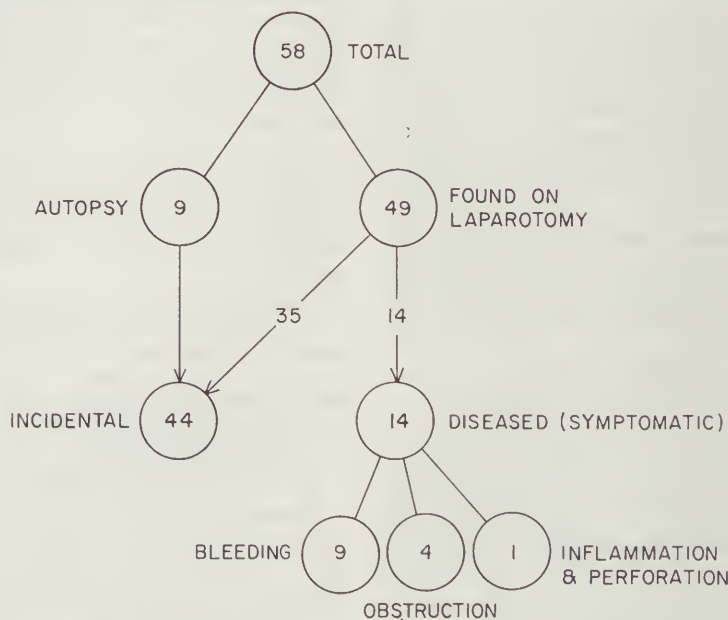


FIGURE 1: Summary of presentation of total 58 cases studied.

old baby girl who had massive rectal bleeding from the diverticulum. The oldest patient was found during an autopsy in a 82-year-old man who died of acute myocardial infarction; however, the oldest diseased diverticulum was found in a 60-year-old woman who presented with rectal bleeding. In this series, the peak incidence was found in the third and fourth decade; however this includes both diseased and incidental cases. A close to 3:2 male: female ratio is noted. (Fig. 2) Furthermore, 57 cases recorded were Caucasians. Only one out of the total 58 was black.

Clinical Presentation

Of the 14 symptomatic cases, the most

common presentation was rectal bleeding. Next came obstruction, inflammatory processes and perforation in descending order (Table 2). Among the nine patients who presented with rectal bleeding, a preoperative diagnosis of Meckel's diverticulum was made only in two, one by 99m-Tc pertechnetate scan and the other by small bowel series. The diagnoses of the remaining seven were "GI bleeding from unknown origin." On operation, all were found to have bleeding Meckel's diverticuli. Among the four patients presented as intestinal obstruction, one was found to have an intussusception of the ileum which the Meckel's diverticulum served as a leading point. In the second, the patient had the Meckel's diverticulum existing

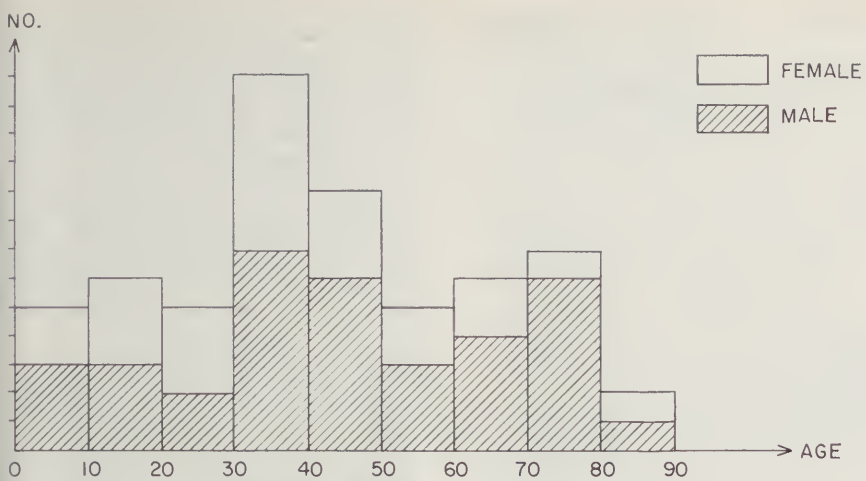


FIGURE 2: Age and sex distribution.

TOTAL DISEASED CASES	14	100 %
RECTAL BLEEDING	9	64-2 %
OBSTRUCTION	4	28-5 %
INFLAM. & PERFORATION	1	7-3 %

TABLE 2: Clinical presentation of symptomatic cases.

MECKEL'S DIVERTICULUM	2	14-4 %
GI BLEEDING ORIGIN ?	7	47 %
INTESTINAL OBSTRUCTION	2	15-5 %
INTUSSUSCEPTION	1	7-7 %
INCACERATED FEMORAL HERNIA	1	7-7 %
ACUTE APPENDICITIS	1	7-7 %
TOTAL	14	100 %

TABLE 3: Preoperative Diagnoses.

into a femoral hernia sac with a loop of ileum. One case presented as acute appendicitis and was found on exploration to have a perforated Meckel's diverticulum with diverticulitis. The appendix was normal. A summary of the preoperative diagnoses on the 14 symptomatic cases is presented in Table 3. Also, the age and sex distribution of these 14 cases is shown in Fig. 3.

Pathology

Of the 58 cases described, the histologic findings of the Meckel's diverticuli were recorded in only 50, among which gastric mucosa was found in 10. Four of these were associated with rectal bleeding. Again, among the 10 cases, two contained both heterotopic, gastric and pancreatic tissues, one of which was associated with bleeding. The location of the Meckel's diverticuli was recorded in only 26 of the total 58 patients, the furthest one from the ileocecal valve being 100cm. and the nearest one 3.8cm. The majority were within the 30-60cm. range. As for the size of the Meckel's diverticuli, the largest was 9cm. in length and 3cm. in average diameter, whereas the smallest was 1.3cm. in length and 0.5cm. in average diameter. The rest of the pathological findings was detailed in the previous paragraphs.

Discussion

Meckel's diverticulum, despite the fact that it is neither a rare nor frequent anomaly, still enjoys certain popularity in the past and current medical literatures because of its many interesting features. Numerous reports and case studies have been published. In the present series, although some of the statistics reported do not correlate well with the currently-accepted figures, since this is not a randomized prospective investigation and represents only a particular community studied, the major emphasis of this paper is to the various presentations of the diseased Meckel's diverticulum to which the surgeon should pay particular attention in the differential diagnosis of acute abdominal catastrophes.

Embryologically, Meckel's diverticulum represent the remnant of the unobliterated omphalomesenteric or vitelline duct. During the first few weeks of fetal life, the primitive yolk sac is divided into two portions connected by a tube contained in a structure which in later stages becomes the umbilical cord. The outer portion of the divided primitive yolk sac is referred to as the yolk sac, while the inner portion develops into the midgut. The tube which connects these two portions is the omphalomesenteric duct which, in normal development, becomes obliterated around the seventh week of fetal life. Total or partial failure of obliteration results in the presence of Meckel's diverticulum and its allied anomalies. Total failure of obliteration gives rise to a persistant omphalomesenteric duct with umbilical fistula. Partial

a partially-obliterated, omphalomesenteric duct with distal fibrous band formation around which torsion and volvulus of the ileum occurred. In a third, the obstruction was found to be caused by segments of

diverticulum. A polypoid lipoma was also found in the lumen of the ileum, however, no inflammatory process was found. In a fourth case, the patient was found to have a Meckel's diverticulum incarcerated



FIGURE 3: Age and sex distribution of "diseased cases."

TABLE 4: A comparison of incidence of "diseased" Meckel's diverticulum in different series, reproduced after Kher.⁸ (In Bibliography.)

Authors	Study Period	Total Cases Presented	% Diseased
Brookes ¹	1942-52	43	86.1
Brown et al ²³	1936-50	37	50.0
Davidson and Hirsch ⁵	1938-54	23	86.9
Dowse	up to 1961	100	67.0
Freeman et al ⁹	1942-52	45	73.3
Gross ⁶	up to 1950	149	100.0
John et al ⁷	1937-58	143	15.4
McParland and Kiesewetter	1940-55	84	59.5
Moore	1938-56	46	100.0
Taneja ²⁴	1956-61	13	84.6
Taneja ²⁴	1956-59	20	85.0
Kher et al ⁸	1930-70	123	37.4
Rutherford et al ¹³	1939-64	148	80.0
Present series	1970-75	58	24.1

failure of closure on the mesenteric or intestinal side results in Meckel's diverticulum with or without fibrous connection to the umbilicus while partial patency on the umbilical side results in umbilical sinus.⁸ Schwartz has estimated the incidence of Meckel's diverticulum along the anti-mesenteric border of the ileum to be 82.5%, partial obliteration with distal band 10% and persistent vitelline duct with umbilical fistula 6.5%.⁷ among all vitelline duct anomalies.

As generally-accepted, the incidence of Meckel's diverticulum is around 2% of the population. In the total 58 cases reviewed, the lesion is the cause of clinical disease in 14 cases which makes up to 24.1%, a figure consistent with the range of 15-25% in numerous similar studies.^{1, 9-11}

This means that one out of every 50 persons in the general population has a Meckel's diverticulum and that one out of every 200 persons has a Meckel's diverticulum which would give rise to clinical disease. The clinically-symptomatic entities usually become manifested in childhood. It is reported that about half

of these patients are seen before the age of two;^{6, 12-13} however, the present series is not consistent with these figures in that only two of the 14 symptomatic cases were two years old or under and six of the 14 were seen before the age of 20. A comparison of reported incidences in various series is presented in Table 4.

The most frequent presentation of a symptomatic Meckel's diverticulum is rectal bleeding. This is followed by intestinal obstruction and inflammation with or without perforation in descending order. Such findings are consistent in various studies. In Maguid's (et al) series of 60 patients, 32 had profuse rectal bleeding, amongst which 19 had peptic ulceration, 19 presented as intestinal obstruction and nine with perforation and peritonitis.¹⁴ In Rutherford and Aker's series of 80 diseased diverticuli, 43 had rectal bleeding, 26 intestinal obstruction, eight primary diverticulitis and three with perforation.¹³ The present series also demonstrated similar findings. Besides the usual pictures, particularly-rare presentations have been recorded. Martinez and Silbiger reported two unusual cases in

which one Meckel's diverticulum contained a calculus presenting as a triangular calcification in the RLQ of the abdomen in a nine-year-old boy and, in another case, the Meckel's diverticulum was a leading point of a ileocolic intussusception in a 11-month-old female.¹⁵

Many other reports also demonstrated presence of enteroliths in the Meckel's diverticulum.¹⁶⁻¹⁹ In 1947, Moses reported a first case of peptic ulcer developed in a Meckel's diverticulum which has bled into the peritoneal cavity and the patient presented with shock and evidence of pneumoperitoneum.²⁰

The preoperative diagnosis of symptomatic Meckel's diverticulum is frequently based on clinical manifestation alone or by exclusion. Although roentgenographic techniques including intraluminal contrast or angiographic studies have been successfully-used to demonstrate the Meckel's diverticuli, their overall accuracy have always been disappointing.²¹ Thus, in the majority of cases, the diagnoses are confirmed only on laparotomy; however, a convenient, non-invasive method of fairly-satisfactory accuracy has been suggested and repeatedly reported in recent years. This includes an abdominal scan with ^{99m}Tc-pertechnetate. In 1970, Jewett et al reported two successful demonstrations of Meckel's diverticuli by Tc scan.²² At the same time and thereafter, numerous authors have reported satisfactory results. The positive scan is based on the active uptake and secretion of the pertechnetate ion by gastric mucosa (ectopic in the Meckel's diverticulum). Since more than half of the symptomatic Meckel's diverticuli contain such heterotopia, the yield is naturally high.⁵ According to Berquist et al, the diagnostic accuracy is particularly-high (approaching 100%) when the symptoms are caused by hemorrhage.¹² On the other hand, reports of false (+) and (-) are not infrequent.²³⁻²⁴ In these studies, hematoma in the wall of the intestine, peptic ulceration of small intestine, partial obstruction of the ureter resulting in accumulation of isotope proximal to the site of obstruction, hydropelvis with collection of isotope in the dependent part of the renal pelvis and aneurysms of the abdominal vessels have all been blamed on the causes of the false positives.²⁵

As universally-known, heterotopic gastric, pancreatic and duodenal mucosa (tissue) are commonly-seen in histopathologic studies of resected Meckel's diverticuli, especially those which provided symptoms. Griffin has stated that 50% of patients with Meckel's diverticulum have heterotopic tissues.⁸ Rare pathological findings, such as sarcoma arising in the Meckel's diverticulum, have also been reported in the literature.²⁰ While surgical removal of the diseased Meckel's diverticuli is mandatory, the prophylactic removal of the diverticuli found incidentally is also indicated when feasible.

Summary

A retrospective clinico-pathologica

study of 58 cases encountered during the five-year period of July, 1970-June, 1975 in Baltimore's St. Joseph Hospital is presented. A major emphasis is laid on the clinical presentations: 44 of the total 58 cases reviewed were asymptomatic, encountered only during laparotomy for unrelated causes or during autopsy; however, when diseased, these previously-silent and apparently-innocent diverticuli can lead to abdominal catastrophies. The most frequent presentation is massive rectal bleeding.

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Doctor Versus Lawyer: Why It Cannot Be Done in Maryland

By JOHN F. KING, Esq. and M. BRADLEY HALLWIG, Esq.

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Introduction

Maryland physicians who have been victimized by malicious, groundless and vexatious malpractice suits often consider countering the patient and the patient's attorney. Under the present State of Maryland law, such a countersuit cannot be maintained unless the physician has suffered some "special injury" as a result of the litigation about which he/she complains. This necessary "special injury" must be one of two things: a wrongful seizure of his/her person (imprisonment) or the wrongful seizure of his/her property (attachment). Only very rare cases (and almost never a malpractice case) involve either sort of special injury. The majority of American states have no special injury requirement for countersuits of this kind, but a minority (Maryland included) follow what has become known as the English Rule and insist on one of the two types of special injury before they will allow recovery.

As counsel to the Medical and Chirurgical Faculty, we have for the past decade been promising the assembled members at Executive Committee meetings, at House of Delegate meetings and wherever, that as soon as the proper facts came along, this so-called English Rule would be challenged in court in a suit filed on behalf of a physician against a lawyer and a patient for wrongfully charging the physician with malpractice. Physicians have been urging us to strike back, citing cases from Illinois and Florida where countersuits by physicians received national publicity. Our admonition has always been, "We haven't had a strong case factually yet. It's important to proceed only with a strong case for fear of being guilty ourselves of the very wrong about which we complain."

Finally, the right case *did* come along. Suit was filed against a lawyer and a patient, but in spite of the aggravated circumstances, the highest court in Maryland chose to ignore the case and thus to persist in protecting the Bar by its adherence to the ancient, ill-conceived English Rule requiring special injury. We present here some of the facts of the case, along with a brief discussion of the English Rule. The case is reported not only to inform, but to illustrate the need for legislation that would abolish the so-called English Rule as applied in Maryland, which effectively prevents retaliation. This remedy should be available not only to physicians, but to any aggrieved citizen who suffers because a lawyer not only files, but persists in prosecuting, an absolutely groundless claim.

The Case

The physician involved was an obstetrician-gynecologist. The patient was seen by him on only four occasions, in January and October, 1967 and in February and October, 1968. Each visit was for a gynecological examination and for the continuation of her birth control pills, which had been prescribed for her originally by another doctor. The physician found nothing remarkable during any of the four examinations and continued her prescription. After the October, 1968 office visit, the patient failed to return for her next scheduled examination and the physician never examined or treated her again.

He next heard from her in November, 1971 when she filed a malpractice suit against him as well as a number of other physicians. The Complaint specifically charged him with negligently failing to recognize symptoms that allegedly developed in February or March, 1969 (after her last visit) indicating "thrombophlebitis" and failing to advise her to cease taking the drug Norinyl in light of these symptoms. The physician was shocked by these charges inasmuch as he had performed a thorough and proper examination each time he had seen the patient and the patient

had never exhibited any symptoms that contraindicated Norinyl while under his care. An answer was filed denying the allegations.

For a plaintiff to prevail in a medical malpractice case of this kind in Maryland, a medical expert must testify that the care rendered was contrary to accepted medical standards. If a plaintiff fails to produce such expert testimony, then the trial judge will enter a judgment in favor of the defendant-physician, and the jury will not be permitted to consider the case. Consequently, if a plaintiff's attorney is unable to produce such an expert by the time of trial, he/she knows, or ought to, that his/her case cannot possibly be successful; the law forbids it.

As part of the normal pretrial discovery, it was determined that each of the experts relied on by the plaintiff were of the opinion that the gynecologist's treatment had been proper.

Despite the fact that the case against the gynecologist was doomed for want of expert testimony, the patient and her attorney continued to prosecute the case against him. It finally came to trial in Baltimore in November, 1975, and, after the plaintiff had finished putting on all of her evidence, the judge, as expected, directed that judgment be entered in favor of the physician.

Here was the case to challenge the English Rule. A more groundless suit could hardly be imagined. The very experts named by the plaintiff testified that there was nothing negligent about the care rendered by the physician. How could there be a justification for filing and continuing to prosecute such a frivolous malpractice claim?

Accordingly, in June, 1976, a countersuit was filed against both the patient and her attorney. It was alleged that the two defendants knew or should have known that their case was without merit, and that, despite this knowledge, they continued to prosecute their suit. The damages claimed included emotional and mental distress, loss of time from practice and injury to professional reputation. We could not, and did not, allege special injury.

As expected, the suit was challenged on the grounds that Maryland law did not permit recovery unless a special injury is alleged. The trial judge, bound by existing precedent from the Court of Appeals, was compelled to grant a motion to dismiss the case. This dismissal, by following precedent, set the stage for a direct, inescapable challenge of the English Rule by petition for appellate review by the highest court in Maryland, the Court of Appeals, if that court agreed to hear the appeal. As are the trial courts, the Court of Special Appeals (Maryland's intermediate appellate court) is bound by Court of Appeals precedent and cannot overrule a prior Court of Appeals decision on point. Only the Court of Appeals can overrule itself, but not every case will be heard by that Court. The law grants an absolute right of appeal only to the Court of Special Appeals. In our case, this appeal was essentially useless because that court could not overrule the prior Court of Appeals decisions that had established and perpetuated the English Rule. To reverse the trial court's dismissal, the case had to be decided by the highest court, the Court of Appeals.

Unfortunately, the Petition for Appellate Review was denied. Apparently, not even three of the appellate judges out of the total of seven had an interest in hearing the case, such petitions being usually granted if three judges so desire. It is clear, therefore, that the Legislature must be persuaded to change the law because Maryland's highest court declined even to review its previous rulings perpetuating the English Rule.

Conclusion

"Every citizen has three important interests which, among others, are protected by the law of torts—interest in reputation and honor, interest in bodily freedom and interest in financial security. A tort action for defamation provides protection for the first of these, while an action for false imprisonment protects the second. An action for malicious prosecution protects all three."¹

There is a fundamental maxim of Anglo-American jurisprudence that says "There is no wrong without a remedy." The malicious institution of groundless civil proceedings is clearly a wrong, but one that the Maryland courts have chosen to tolerate.

The Maryland precedent provides a safe harbor for persons who would use the legal system as a tool for blackmail. Their victims can either pay the blackmailer's price or pay the price for litigating out of principle to vindicate their honor; in either case, the injury ought to be compensable. A prudent person may decide to settle, and pay the cheaper price regardless of principle. Such a condition is an outrage. For the legal system, through which society compensates those who have been wronged, to be itself the medium through which an obvious wrong can be committed yet compensation be denied is anarchy. Remedial legislation is needed to correct the problem, not only for physicians, but for all citizens injured by irresponsibly-prosecuted litigation.

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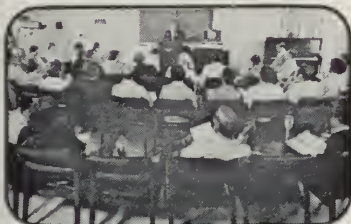
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Peritoneal Adhesions: Where Do We Stand?

By A. ALAMEDDINE, MD

Dr. Alameddine can be contacted for reprint and other data at 28 Highland Ave., Somerville, MA 02143.

Intraperitoneal adhesions are noted with sufficient frequency to be a cause for concern in all patients following abdominal explorations. Innumerable experimental models and methods have been used in an effort to evaluate a variety of ways to control or reduce the occurrence of postoperative peritoneal adhesion. Many substances have been proposed, locally or systemically, to prevent adhesions, among them: Dextran, Heparin, Proteolytic enzymes, antihistaminics and steroids, silicone fluid and lubricants, to cite only a few. Unfortunately, no data dealing with the effectiveness of these substances are obtained in preventing adhesion; however, there is strong evidence to suggest that they may be of some benefit, and this alone is a sufficient "raison d'être" for a justification for expanded use in humans. Clinical evaluation of the various means of control and recurrence is urgently needed.

The purpose of this article is to review the pathogenesis and the therapy and methods of prevention of peritoneal adhesions, to be undertaken once a definitive diagnosis has been achieved. The suggestions to be discussed illustrate some of the therapeutic implication of the pathologic process. Although most of this information has already been published in various medical journals and publications, it is hoped that this presentation will serve as a simplified guide.

The most common cause of intestinal obstruction is adhesion: the incidence goes as high as 50%,¹ with an overall mortality rate ranging between 4.5-24%.²⁻⁴ The presence of adhesions after laparotomy has been recorded in 91.1%.⁵ Fortunately, all adhesions do not cause distress. An interesting fact is that the frequency of recurrence is higher among those previously operated upon (relaparotomy) than among those not previously operated upon; it is stated that "every seventh, (of operated patients), had fallen a victim to recurrence, and of those who escaped recurrence every fifth had considerable distress."⁶ Distress is regarded as subobstruction attacks with intervals of pain and possibly vomitings. On the other hand, the "distress" frequency is distinctly higher at the second operation (76%). The fundamental process by which the adhesive band is formed is still a mystery, but a number of theories have been proposed. Hippocrates and Galen recognized the "belly passions." As early as 1849, famous names in medicine like Cruveilhier⁷ and Rokitsanski suggested the coagulated lymph as origin of temporary fibrinous adhesions. Hunter⁹ described as sticky substance, "nature's glue" or "gluten," holding the bowel surfaces together. In some earlier report¹⁰ the emphasis was on the idiosyncratic interpretation, such as 'fibroblastic diathesis."

Ellis¹¹ strongly advocates that bowel wall ischemia and trauma, whether mechanical, bacterial or chemical, appear to be one of the etiologic agents in the production of adhesions.

A rough pair of hands, an excessive and careless use of dry gauze pads for sponging, an improper choice of instruments and sutures, a lack of knowledge in dissection techniques and tissue crushing with big "bites"—in other words, abuse of Halsted's principles of surgery—all lead to the outpouring of fibrinous exudates with conversion into organized thick creamy bands, then to development of fibrous strands which bridge the peritoneal membranes. There is no need for a "tooth brush" or "sand papers" rubbing to cause the injurious insult to the intestinal serosa. Gervin¹² (1973) stated that any abrasion of the bowel wall causes histamine release and a decrease in fibrinolytic activity of the serosa, which is necessary in the prevention of adhesions. Fortunately, most of the fibrin are dissolved and are therefore transient.

The literature is replete with data showing that foreign bodies¹³ like starch,¹⁴ talc,¹⁵⁻¹⁶ iodine, and phenol,¹⁰ etc., increase the likelihood of capillary "oozing" of fibrin. The presence of blood

in the peritoneal cavity may be disadvantageous to the patient because of the increased post-operative morbidity, e.g. infection and ileus; however, a small amount of uninfected blood would cause no irreversible harm and be absorbed within 10-16 days.^{7, 17} Tissue irrigation with "hot" physiologic sterile solution at temperature greater than 40° centigrade causes injury by inducing hypermetabolism exceeding the capacity of the available blood supply, thus cell death and decrease in the rate of epithelialization.¹⁸

Two raw (denuded) uninjured serosal defects that are lying against each other endothelialize separately without fusing together as a rule.^{6, 19} The visceral healing is faster (five days) than parietal (eight days).²⁰

The literature has been and continues to be plentiful with regard to methods of accomplishing adequate prevention of new adhesion formation. It must be emphasized that there is little room for any hard and fast dicta, since there are many factors that influence treatment. Generally, when a multiplicity of different therapeutic regimens exists for a given condition, the reason is that none of them is completely or uniformly effective, that certainly is the case for the prevention of peritoneal adhesions. Undoubtedly, the mere limitation of peritoneal insult would do most of the "job;" for, otherwise, fibrin would deposit at anywhere from 10 minutes to two hours.²¹

Other "ingenious" methods have included¹⁰ placement of sheets of fresh bladder strips, cargile membrane (osc peritoneum), human amniotic and beef allantoic membranes, placement of lubricants like gum arabic, collodion, Vaseline, albumin and paraffin, etc. Empirically, the effect is mechanical by keeping apart injured peritoneal surfaces. By the same token, post-operative peritoneal lavage (with removal of transudates) is still subjected to criticism.²²

I believe that "drawing" the omentum down over the bowels would prevent only the visceroparietal adhesions, but not the interserous ones.

Intraperitoneal administration of Betadine® antiseptic solution (Polyvinylpyrrolidone or Povidone iodine), has been recommended at laparotomy if adhesions are expected.²³⁻²⁵ Certainly this substance is appealing and offers many theoretic advantages because of its safety,²⁶ efficacy against suppurative peritonitis²⁷ and non-interference with normal healing processes.²⁸ Other suggested methods of prevention or "destruction" of the adhesive band may be considered under the following categories which are a useful adjunct to the surgeon's armamentarium:

1. Inhibition of the coagulation of peritoneal fibrin exudate: the use of Dextran 70 or 75 intraperitoneally as advocated by Neuwirth²⁹ (1974) and others³⁰ is slowly gaining in popularity, although it had not been the favored method for routine use in humans. While the available data are insufficient to establish its role, continued trial is certainly warranted. The risks of hemorrhage from the use of Heparin³¹ far outweigh any prophylactic action on the fibrous exudate.
2. Digestion of fibrin already deposited upon the peritoneal surfaces:

There has been considerable debate about the value of Proteolytic Enzymes, Streptokinase, Urokinase, hyaluronidase and Papase (papain).³²⁻³⁴

A recent study by Gevin et al (1973), indicates that intraperitoneal Urokinase (in dogs) achieved not only a reliable, but also a safe, method for the prevention of adhesions; for no side-effects on coagulation factors or wound healing were experienced.

3. Inhibition of fibroblastic proliferation: In recent years, a number of papers have appeared reporting results of locally applied steroids and antihistaminics.³⁵⁻³⁶ Unfortunately, intraperitoneal steroids in rats might be associated with a high incidence of wound infection and breakdown of anastomoses.

Epilogue

In conclusion, until the ashes from the fires of controversy have settled, we believe that although none of these techniques have been universally effective for the control of adhesions, with further understanding of its etiology by experimental patient and clinical investigation, perhaps newer knowledge in the treatment of peritoneal adhesions will be forthcoming. Perhaps a hitherto unknown modality of treatment will appear upon the scene.

Much can be accomplished through an intelligent approach based on available knowledge and sound surgical principles. Last, but not least, one should view new suggestions and designs skeptically: "No one should test the depth of a river with both feet."

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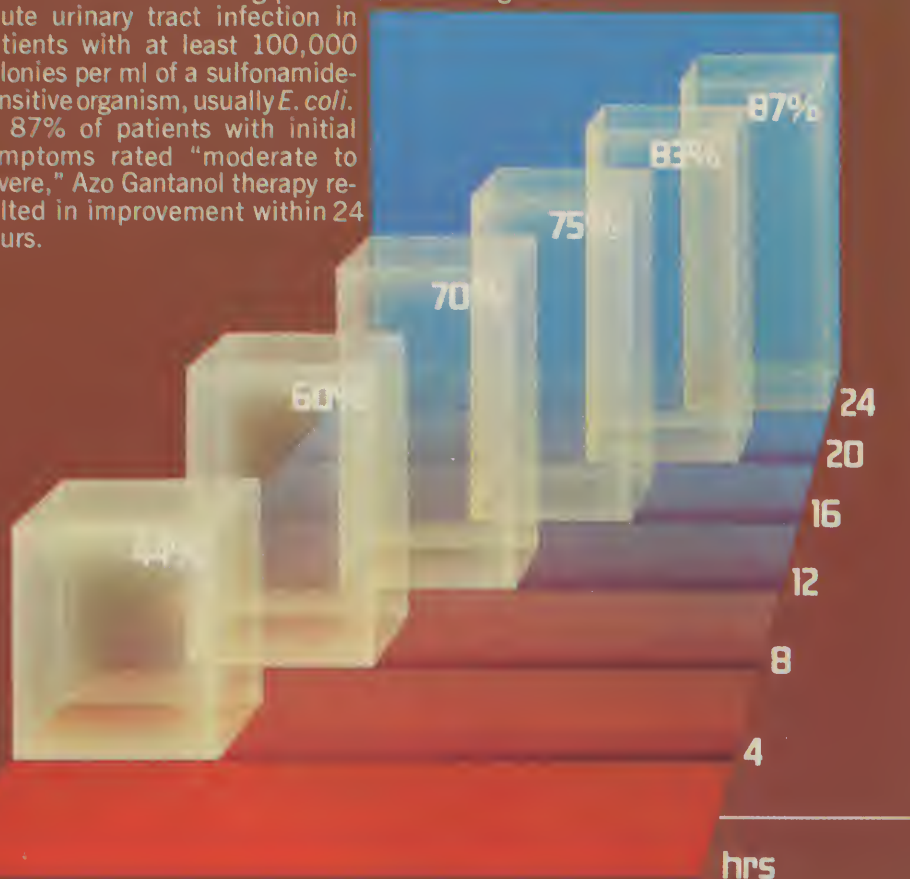
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Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term or during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruption, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents exist.

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NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine. **Supplied:** Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



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Ileostomy without External Appliance: The Continent Ileostomy (Kock Pouch)

By JACOB C. HANDELSMAN, MD and RONALD H. FISHBEIN, MD

These procedures were carried out at the Johns Hopkins Hospital, the Sinai Hospital of Baltimore and the Greater Baltimore Medical Center of Baltimore, MD. Both authors are Associate Professors of Surgery at the Johns Hopkins University School of Medicine. For reprint and other data, contact Dr. Handelsman at 220 W. Cold Spring Lane, Balto., MD 21210. (Artwork by Walter Handelsman.)

Introduction

The patient who is in need of a permanent ileostomy because of proctocolectomy has a greater assurance of an unburdened life today than ever before. The modern Brooke ileostomy and its modifications¹ and a number of simple, effective appliances have assisted him immeasurably in the management of his stoma. In addition, the new professionals, trained stoma specialists, are an influential support, both psychological and physical. Ostomy clubs are flourishing for the mutual benefit of their members. It has been estimated that some 85% of those with conventional ileostomies are satisfied.²

Nevertheless, a significant number of these patients find their social, physical or sexual adjustments difficult or impossible. Most often these difficulties center on the need for an appliance to be worn with the ileostomy.³

Dr. Nils Kock of Gotteborg, Sweden has devised a surgical procedure which makes it possible for a patient with an ileostomy to forego the use of a bag. In this operation, an internal reservoir and a valve are fashioned of the ileum immediately proximal to the ileostomy. The valve is designed to be fluid and gas-proof, and the patient empties himself periodically through the day by the insertion of a catheter.⁴

This option for the ileostomy patient has aroused great interest and has proved attractive to a number of patients. Performed now by a number of surgeons in Sweden, in this country and in England as well as other lands, several hundred such procedures have been carried out. Beahrs of the Mayo Clinic, and Gelernt at the Mt. Sinai Hospital in New York, have been its principal practitioners in the United States.⁵⁻⁶ Our own experience with 24 cases has drawn upon their work, has permitted us to introduce some innovations and to draw some conclusions.

This report describes our experience with the continent ileostomy (Kock pouch). The series includes patients in whom this procedure was carried out to revise a preexistent conventional ileostomy, as well as cases where the proctocolectomy and continent ileostomy were carried out simultaneously. Insofar as possible, we shall refrain from discussing the indications for the proctocolectomy.

The Operation

The operation of continent ileostomy constructs a reservoir, a valve to retain stool and gas and an ileostomy stoma through which the reservoir is evacuated.

The ileum having been transected when the colon is removed, a point 45 cm. proximal to the end is identified. Proceeding distally from this point, 30 cm. are bent into a "U" configuration to create a common chamber (the reservoir). A continuous catgut suture is placed to make a common wall (Figure 1). This wall is then incised and the suture line reinforced with a second row of catgut (Figure 2). We add support with intermittent interrupted sutures of non-absorbable material. The posterior wall of the common chamber is thus made, and the open chamber leads to the terminal 15 cm. of ileum.

This terminal 15 cm. of ileum is intussuscepted backwards through itself into the reservoir. A 4 cm. intussusception is desirable. This "nipple" so created will function as a valve (Figure 3). There is significant technical work needed to maintain this valve in position. The mesentery, obviously, resists the intussusception and may have to be thinned. At the same time,



FIGURE 1: Beginning 45 cm. from its transection, 30 cm. of ileum is sutured into a loop which will be fashioned into a reservoir.

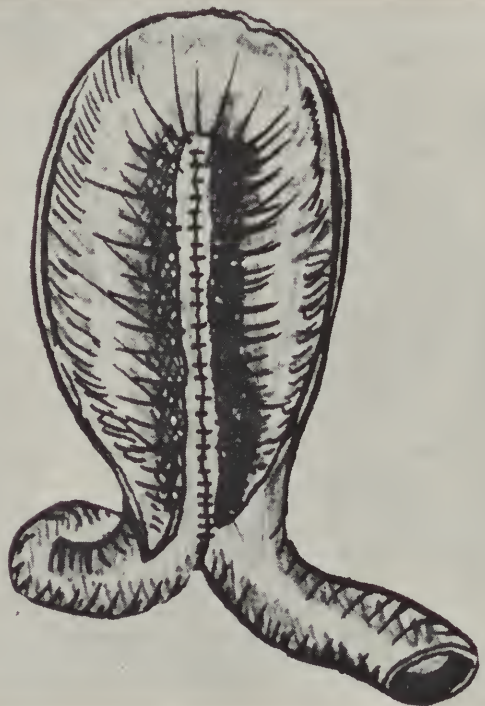


FIGURE 2: Incision of this loop, and a reinforcing suture line construct the posterior wall of the reservoir (pouch).

care must be taken not to occlude its vessels, lest gangrene of the valve occur. We have employed four steps:

The serosa of the bowel to be intussuscepted is intentionally injured by scoring, abrading or burning with the cautery. This promotes adhesion after the inversion.

Following Gelernt's technique,⁶ we then place three or four pairs of successively-inverting seromuscular sutures close to and paralleling each side of the mesentery. As these are successively tied, the mesentery is intussuscepted without any suture crossing it. The remainder of the intussusception is completed and three additional parallel rows of through and through sutures placed.

As a fourth measure, we then suture the exterior of the intussusception where it enters the pouch in a particular way.⁷ The ileum entering the intussusception is rotated 10°-20° to offset the mesenteries. Each mesentery is carefully entered to expose the bowel wall. A suture is placed from this point to the contacting serosal wall and a row of interrupted sutures placed circumferentially. A large-bore catheter or sound is used as a stent during this part of the procedure.

Attention is then returned to the reservoir. The posterior wall is folded over anteriorly (Figure 4) and sutured closed. Two rows of catgut close the chamber (Figure 5). We reinforce this long suture line with several non-absorbable sutures.

The pouch is passed through the fold in the mesentery so that it will present anteriorly and down with the distal ileum at its superior margin.

This folding of the chamber wall results in peristaltic forces at right angles to each other. It is felt that this tends to negate their effectiveness, reducing the forces which would ordinarily respond to the obstructing valve. Gadacz's observation indicate, however, that a measurable, significant pressure occurs.⁸ The afferent loop is occluded and the pouch is filled with air and then with fluid to test the competence of the valve. Intubation releases each test-load.

The pouch is now securely-sutured around the opening made in the abdominal wall and the ileal end is passed externally. These sutures are positioned along the circumference of the entrance of the intussusception. The protruding ileum is amputated flush with the abdominal wall, keeping the distance from the valve outward at a minimum and as straight as possible to facilitate intubation. Interrupted sutures join the end of the ileum to the skin.

Because there is no need to provide space on the abdominal wall for an appliance, the stoma may be set in a low position, near the groin, for cosmetic reasons. The ileostomy may also be made flush with the abdominal wall.

The pouch is intubated and the tube sutured in position, to remain there for two weeks or more while healing occurs. This keeps the pouch emptied and minimizes pressure against the sutures. The reservoir capacity at this time is about 50 ccs. Over the ensuing weeks, it increases rapidly to a volume of 300 to 700 ccs. or more.

The patient must intubate the ileostomy three-five times daily. One of three types of catheter seems to work best and individual preference comes into play. Most patients prefer the Dow-Corning silastic tube or the Medina Polyethylene tube (size 28F) (Figure 6.)

High-residue foods—especially kernel corn and mushrooms—are to be avoided. After several weeks, however, these patients are on no restrictions beyond those given to persons with a conventional ileostomy. If the tube plugs, it is flushed and inserted again. Each emptying requires three-six minutes, and can be done in any toilet or bathroom. The patient carries a small rubber ear syringe, and if stool is too viscous, he irrigates 30-50 cc. of tapwater from any nearby source. For this, the total amount of time required is probably 30 minutes daily when the routine is established.

The Physiology of The Pouch

There appears to be little, if any, troublesome physiologic effect from the pouch. The alterations of bacterial flora which have been described have not appeared to be detrimental.⁹ Jagenberg has described the absorption from the pouch. Qualitatively it appears to be midway between normal ileal absorption and that in a patient with conventional ileostomy.

Stasis phenomena have been noted by Schjonsby and colleagues.¹⁰

The amount and force of peristalsis varies considerably. Generally, when the pouch is full, the patient is aware of a sense of tightness or weight in the area. Colic has not been reported to us. It is not unusual, however, for the patient to experience "gassy" sensations during the first two or three weeks after the surgery and these may be quite uncomfortable. This discomfort abates spontaneously.

Gadacz and his colleagues report that pouch mucosa resembles normal ileal mucosa in the manner in which sodium chloride, bicarbonate and glucose are absorbed and excreted.⁸



FIGURE 3: The terminal ileum is intussuscepted backwards into the unfinished pouch (lower right of pouch). It is secured in this position by sutures placed in a variety of positions.

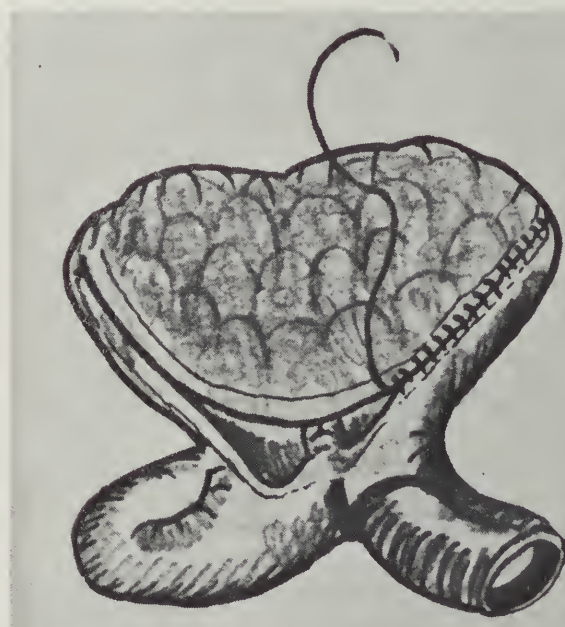


FIGURE 4: The previously-constructed wall is folded anteriorly to form a chamber including the valve constructed by intussusception.

The Complications of The Operation

Intestinal obstruction has been the most common complication experienced. In no instance has this been identified with the pouch. It has accompanied proctocolectomy, and is, of course, well known when such colectomy and conventional ileostomy are performed. Some 5%-15% of patients undergoing proctocolectomy experience this.¹¹

Two serious complications may attend this surgery. The first is leakage from the pouch suture lines during the first several days following surgery. The number and length of the suture lines perhaps predispose to this. We have routinely placed abdominal drains in these cases (when proctectomy has been performed, the pelvis is also drained). While we have reexplored two such cases to drain the peritoneal cavity, more recent experiences of ourselves and others have indicated that the use of antibiotics and suction to the indwelling tube will usually suffice to deal with such leaks.

A second significant complication is leakage from the valve. If this comes about it ordinarily occurs within several weeks to six months following surgery.¹²⁻¹³ Incompetence of the valve occurs when the intussusception fails to hold. Since that portion of the valve which distracts will prolapse out of the reservoir, it takes on the configuration of a diverticulum. This captures the tip of any entering catheter, making intubation difficult. If leakage has not been present, the onset of difficulty with intubation is an ominous sign.

It is almost always possible to repair such a valve or to modify it.¹³

Bleeding from the pouch has been reported.^{6, 13} This may occur from the edge of a suture line or if the mucosa of the pouch is injured by the indwelling tube during the postoperative period.



FIGURE 5: The chamber is closed by suture. It will be turned downward, attached to the abdominal wall and the ileostomy externalized.

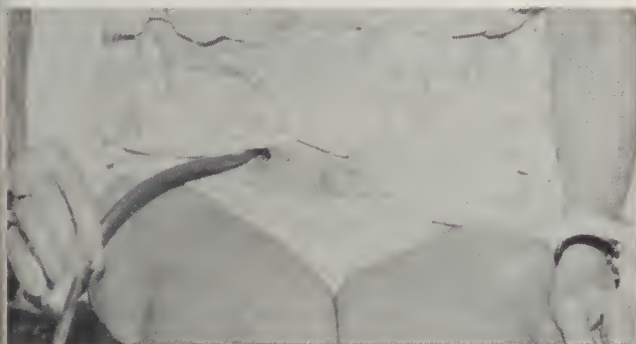


FIGURE 6: The patient is shown sliding the tube into the ileostomy. The open end discharges into a toilet or waste receptacle.

Review of the Current Series

Table 1 describes the patients in this series. The ages and sex merely reflect our selections since a number of criteria are to be fulfilled before we have accepted patients for this surgical procedure.

TABLE 1: Description of 24 Patients

Sex:	17 male;	7 female
Age:	17-65,	17 under 40
Disease:	Ulcerative Colitis	21
	Crohn's	2
	Polyposis	1
Operation:	Colectomy and Pouch	22
	Conversion	2

In Table 2 is shown the interval since surgery. It has been a general experience that complications occur early. For this reason we feel that our experience has validity. It is of interest that valve and pouch apparently are perfectly capable of withstanding the trauma of over a thousand intubations annually.

TABLE 2: Time Since Surgery

Three year or more	seven patients
Two years to three years	five patients
One year to two years	four patients
Five months to one year	eight patients

Table 3 discloses the complications which were associated with the pouch in our series.

TABLE 3: Complications

LEAK FROM POUCH	five
Two drained by secondary surgery	
Three treated by suction	
INCOMPETENCE OF VALVE	five
Four repaired	
Three repaired twice	
One not repaired	
RESECTION OF POUCH	two
One case of small bowel volvulus after several weeks	
One case of Crohn's disease and fistulae.	

Five patients have experienced leakage from the pouch. These leaks were from suture lines as distinguished from the valve. The first two patients, early in the series, were reexplored and drained. They healed after two-three weeks. Later in our experience, three patients leaked and stool issued from the drain site post-operatively. Several days of gentle suction to the pouch and intravenous hyperalimentation resulted in healing.

In five patients, incompetence of the valve occurred during the first several weeks or months after the original surgery. In four patients, corrective surgery was carried out. In three of these patients, two corrections were necessary.

Leakage from a valve should not be prematurely attacked surgically. We have had the experience of seeing transient infection induce temporary leakage and others have reported temporary leakage which rectified itself.

Two pouches have been resected and a conventional ileostomy made. One patient experienced a massive ileal volvulus several weeks after operation with gangrene of the pouch and a significant length of small bowel. The second patient had Crohn's disease which had not been recognized preoperatively. Resection was carried out and a conventional ileostomy made.

At this time, we have one patient in our series with an incom-

petent valve. He wears an appliance and has not undergone any corrective procedure.

Summary

In summary, 21 patients have a satisfactory pouch and valve representing 88% of the original group as shown in Table 4. Seven have needed more than one procedure to attain this. In two instances, the pouch was sacrificed. One patient awaits correction. There has been no mortality.

Discussion

If this procedure is to merit a position in the surgical armamentarium, it should fulfill two basic requisites. First, it must satisfy those who have selected it in order to meet their needs. Second, it must be within the capabilities of a number of surgeons and the clinics in which they practice.

Our patients have had a very positive attitude toward this procedure. They represent a carefully-selected group. We have attempted to be objective in describing the advantages and the hazards and complications of the procedure to them. We have insisted that the patient take a period of time to consider the specific pros and cons of the pouch versus conventional ileostomy.

We have rejected applicants for whom we felt that the likelihood of failure was unusually-high. The physical demands of repeated intubation may preclude its use for the elderly patient, for those too young or for those with specific physical infirmities. Problems of emotional instability may also be a contraindication. Nevertheless, advanced age must be carefully-weighed. Our 65-year-old patient would give no serious consideration to a needed proctocolectomy until he learned of continent ileostomy. His experience has been good, and unaffected by his years.

Obesity may pose forbidding technical difficulties and will preclude the surgery for some candidates unless it is corrected.

We have attempted to exclude patients with Crohn's disease from this surgery. The uncertain course of the disease and the danger that the bowel or the pouch itself may be affected make it too unsafe. Most series include cases of Crohn's disease which had been misdiagnosed before surgery. Two such patients appear among our cases. One was our first patient and has remained well for over three and a half years. The second patient developed a fistula within several weeks of surgery and this pouch was rejected in favor of a conventional ileostomy (Table 3.)

TABLE 4: Results

22 patients of 24 retain pouches
21 of these pouches function without appliance: 88% of the group
No mortality.

Patients who fall into the non-specific group must also be approached with caution. In Kock's experience, they also experienced unusual morbidity.¹³

In this setting, our patients have been enthusiastic about the procedure and satisfied with good results as they were achieved. When imperfect outcomes have demanded further surgery, these patients have all chosen the reparative surgery rather than conversion to conventional ileostomy. We have had similar comment from Beahrs and Gelernt.

It is important to note that patients who have refused a necessary colectomy because of the need for an appliance, have accepted proctocolectomy with a continent ileostomy, as noted above.

Second, the operation is feasible if surgeon and institution will make the necessary commitment. The international interest in the procedure, and its successful execution in a number of clinical settings, hold out the possibility that it may be more generally-available in the future.

It is tempting, therefore, to conclude that we are discussing a procedure which can be freely-offered to large numbers of patients. We feel most strongly that it is necessary for both patient and surgeon to have a clear and honest view of what is involved in this procedure. It takes longer to perform, it carries its own additional morbidity, it demands commitment and attention from attending personnel and is considerably more costly in hospitalization time.

A variety of procedures have been employed to repair leaking valves. It is not the purpose of this communication to dwell upon the technical aspects of these surgical endeavors, but they demonstrated that persistence and resourcefulness are necessary attributes for the surgeon. It is also fair to state that the modifications in suturing of the past few years have been productive. The success rate of valve competence is highly increased.

Two aspects of postoperative management merit comment. The indwelling tube which decompresses the pouch while the valve heals needs constant attention. The pouch effluent after the first two or three days thickens considerably, and the catheter and drainage tubing must be checked frequently during each day to preclude clogging. The patient may be an active participant in this monitoring procedure.

Peristaltic stimulants must be avoided. They impose external and intrinsic stresses on the valve, and disruption may occur.

Intubation is easily-learned. It is our custom to do the first intubation after the indwelling tube is out, and immediately require the patient to insert the tube. The house staff and nurses also intubate the patient. This allays all initial fears that a high degree of technical competence is needed to empty the pouch and is reassuring to all concerned. Patients are proud of this new skill and it proves far easier to learn than the application of an appliance.

A small cotton, cellulose or paper pad is worn over the stoma. This protects the clothing from mucous. The skin needs no protection.

The stoma contracts to 1½-2 cm.

We are, on the whole, increasingly-pleased with what this procedure offers. It seems to us an alternative which may be offered in good conscience. We continue to have reservations about conversions from standard ileostomy if the patient has been doing well; however, if the desire for an altered life-style seems sincere and advisable, we begin the discussions of the surgery.

This operation itself seems destined to improve. In addition, it has provided two valuable spinoffs: first, it has succeeded in making a number of patients accept proctocolectomy. Second, it has stimulated a vigorous effort to explore other methods which permit life without an appliance for the ileostomy patient.

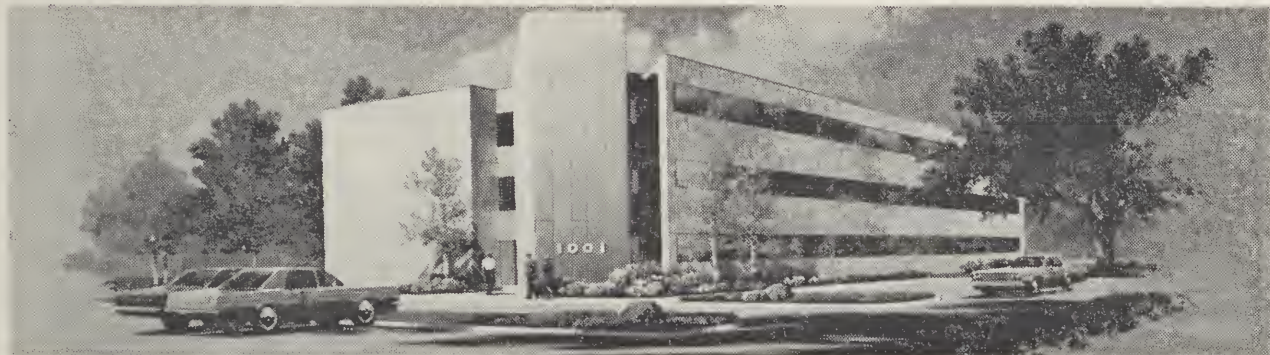
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The Quality of S_1 as an Indicator of Left Ventricular Performance

By WILLIAM F. RENNER, MD and GERARD W. RENNER, AB

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Introduction

The conventional teaching regarding the origin of heart sounds has been that they are produced by closure of the valves of the heart. A newer concept proposes that heart sounds are produced by vibrations of the closed and tensed valves, the subvalvular structures, the myocardium and the intraventricular blood mass.¹⁻³ This cardiohemic concept of the origin of heart sounds has given rise to the hypothesis that pathological changes in the myocardium should be expected to alter the frequency spectrum of the first heart sound.

In 1969 Adolph et al tested the hypothesis that disease states which reduced ventricular elasticity (myocardial infarction) would decrease the frequency content of S_1 and that states which increased ventricular mass (trained athletes) would give a similar result, since frequency varies directly with elasticity and inversely with mass.⁴ Using a sensitive technic for frequency analysis of the first sound during isovolumic contraction time, they recorded peak energy output of the first sound at frequencies between 30-70 c.p.s. They found a consistent and reproducible frequency "fingerprint" in 74 normal subjects and diagnostic patterns in 21 of 24 patients with acute myocardial infarction. In the normal subjects, the maximum energy output occurred at a frequency of 40 c.p.s.; in the post-infarction patients and in the trained athletes, the peak energy output was at 30 c.p.s. The patterns of athletes were similar to those of post-infarction patients.

Using a different technique and less complex equipment, we have performed frequency analyses of the first heart sound in 165 patients. Our findings confirm those of Adolph et al that normal subjects have a readily-recognizable frequency pattern with variants and that this normal pattern is distorted by myocardial infarction. In addition, we have measured the quality or sharpness of resonance of the first sound in terms of a quality factor, Q , used in acoustics to define the sharpness of resonance of a system. The Q factor has proved useful in distinguishing the abnormal pattern of the post-infarction patient from the normal variant of the athlete. The degree of distortion of the normal frequency pattern in relation to the clinical impression of the degree of myocardial damage has been observed.

Method

The equipment has been described in detail in a prior publication.⁵ Briefly, the heart sounds are recorded on a magnetic tape recorder with the patient in the left lateral recumbent position. The sounds are then passed through a sharp audio filter. As the observer listens to the first heart sound, he records the voltage output at frequencies from 20 c.p.s.-100 c.p.s. at increments of 10 and charts the results on a graph. The quality

factor, Q , is calculated from the equation: $Q = \frac{F_r}{F_2 - F_1}$, in which F_r is the resonance frequency and F_2 and F_1 are the two frequencies above and below resonance at which the average power has dropped to one-half its resonance value, i.e., 3 db down (Figure 1).

From the 165 patients in whom frequency analyses were carried out, 54 patients were selected for study in whom there was no reason to suspect abnormality, and a second group of 65

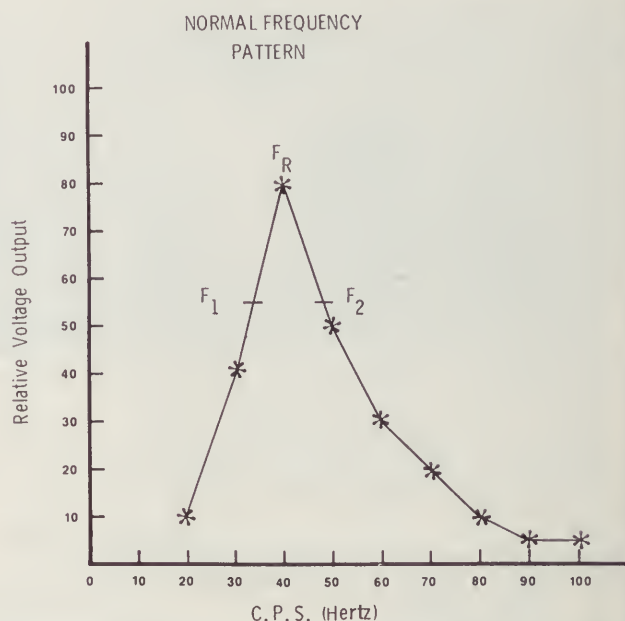


FIGURE 1: A normal frequency pattern from a 53-year-old asymptomatic female is depicted. The peak voltage output is at 40 c.p.s. (F_r). The voltage output falls off sharply below and above 40 c.p.s. F_2 represents the point at which the voltage has dropped to one-half its value, i.e., 3 db down, above 40. F_1 represents 3 db down below 40. The quality factor, Q , of the resonant system equals F_r divided by F_2 minus F_1 , i.e.

$$\frac{40}{47.5 - 33.5} = 2.8.$$

myocardial patients who had had well-documented myocardial infarction. The normal subjects were in general younger; however, the range of ages in the normal controls was from 7-86 years. The 86-year-old gentleman was active, asymptomatic and had both a normal frequency pattern and a normal ECG.

Results

Of the 54 normal subjects, 30 had a peak energy output at 40 c.p.s., 15 at 50 c.p.s. and nine at 30 c.p.s. The nine with peak outputs at 30 c.p.s. were young, physically-active subjects. One was a physical education instructor and had been an Olympic contestant; 52 of the 54 apparently normal subjects had Q factors of two or more (Fig. 2). Of the 65 post-infarction patients, 30 had a peak voltage at 40 c.p.s., 24 or almost half had a peak voltage at 30 c.p.s., and 11 had a peak at 50 c.p.s.; two had a peak at 20 c.p.s.; 63 of the 65 had a Q factor of less than two (Fig. 3). Two had a Q factor of two or more. Both of these had made good recoveries and were asymptomatic. One of the two was two years post-infarction and had had a Q of less than two-three months post-infarction.

Conclusions

Normal subjects have a readily-recognizable frequency pattern of S_1 characterized by a peak energy output at 40 c.p.s. and a sharpness of resonance as determined by the quality factor, Q , of two or more. A variant of the normal pattern has a peak energy output at 50 c.p.s. Athletic individuals often have a peak output at 30 c.p.s.

VARIANTS OF NORMAL FREQUENCY PATTERN

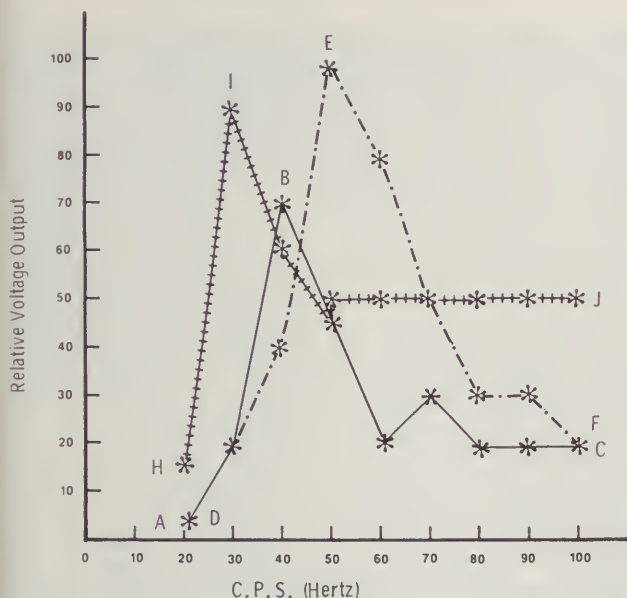


FIGURE 2: Three normal frequency patterns are shown. ABC depicts the common pattern with peak voltage output at 40 c.p.s. with sharp descents on either side of 40 giving rise to a Q of two or more, in this case 2.6. The secondary rise at 70 c.p.s. is seen commonly. DEF represents a common variant in which peak voltage output is at 50 c.p.s. The Q is 2.5. HIJ shows the type of pattern often seen in young athletes. Peak voltage is at 30 c.p.s. Q is 2.7.

ABNORMAL FREQUENCY PATTERN WITH VARIANTS

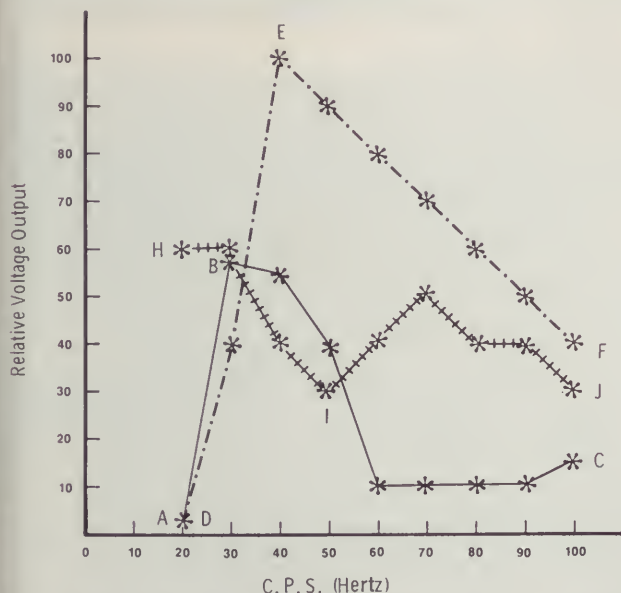


FIGURE 3: Three abnormal frequency patterns, all recorded from post-infarction patients, are shown. ABC represents the prototype. The voltage output is higher at 30 c.p.s. than at 40 c.p.s. The Q is less than two, in this case 1.3. DEF depicts a common variant. The peak voltage output is at 40 c.p.s. The descent from 40 c.p.s. is relatively slow, giving rise to a Q of less than two, in this case 1.2. HIJ was recorded from a patient with an old anterior myocardial infarction and severe angina. It is unusual in that the voltage output at 20 c.p.s. is as high as that at 30 c.p.s. and the voltage at 30 c.p.s. is considerably higher than that at 40 c.p.s. This is thought to represent severe myocardial abnormality.

Post-infarction patients tend to have a lower peak energy output and a Q of less than two, usually close to one.

The degree of distortion of the normal frequency pattern tends to correlate with the clinical impression of the degree of myocardial abnormality.

Frequency analysis of the heart sounds carries no risk to the patient, causes no discomfort and can be carried out quickly and inexpensively in an office setting.

This preliminary exploration of the potential value of frequency analysis of the first heart sound as a diagnostic tool suggests that further clinical investigation is warranted.

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Pulmonary Resuscitation—Howard Atwood Kelly, 1894

By JEAN-MAURICE POITRAS, MD

For reprint and other data, contact Dr. Poitras at 107 Edgerton Rd., Towson, MD 21201; he is also in the Department of Emergency Medicine at North Arundel Hospital, Glen Burnie, MD.

Attempts at pulmonary resuscitation are not new to our generation. In the Book of Genesis, God blows breath into Adam to give him life. The Bible makes other references to pulmonary resuscitation by blowing breath into the mouths of newborns or others who are not breathing. Throughout the ages, there have been countless references of attempts at pulmonary resuscitation.

Howard Atwood Kelly, (1858-1943), one of the greats of the Johns Hopkins Hospital and Medical School, was the possessor of an inventive mind which he made use of to the fullest. One example of his ingenuity and creativity is illustrated in the reprint of a paper by Dr. A. A. Hare, Professor of Therapeutics in the Jefferson Medical College of Philadelphia. In this paper, Dr. Kelly demonstrates his own method of pulmonary resuscitation which, like many others, has now dropped into oblivion.

The paper by Dr. Hare was read before the Johns Hopkins Medical Society on Nov. 19, 1894 and was entitled *The Posture of the Head in Accidents When the Patient is Under an Anesthetic*.

The paper was later published in the *Bulletin of the Johns Hopkins Hospital* of January, 1895.

Dr. Hare discussed the physiology and anatomy of pulmonary arrest, especially with the use of chloroform which he considered could be a dangerous anesthetic, and his methods of treatment with artificial respiration and atropine when pulmonary complications arose. The methods of artificial respiration he discussed were Sylvester's and Marshall Hall's, both of which are long outmoded.

After the completion of Dr. Hare's presentation, there were several interesting discussions by Drs. Kelly, Osler, Halsted, Abel and Theobald, all of whom were apparently well-acquainted with the advantages as well as the dangers of the use of chloroform anesthesia.

The following discussion gives only the comments of Dr. Kelly, but the ideas of others may be read in the original article which is available in our Faculty Library. It is also of note, that, although Dr. Hare is the author of the article and Dr. Kelly only one of the discussors, the two photographs used in the article are those demonstrating Dr. Kelly's discussion.

Dr. Kelly started his comments with a general discussion of chloroform anesthetic and remarked that "Dr. Wood of the University of Pennsylvania had said that a surgeon having a death from chloroform should be indicted for murder." He continued he left the choice of anesthesia up to the anesthetist, the majority of whom chose ether. He, himself, preferred chloroform for most cases, but never tried to influence the anesthetist.

The following paragraphs are taken verbatim from the articles and show some of the problems of the anesthetist of those days as well as Dr. Kelly's method of solving one of the problems:

"Regarding methods of resuscitation, I have found a method of my own exceedingly satisfactory. I have treated about 15 cases with uniform success by this method, which I believe to be the best for keeping up artificial respiration. I find, too, that I have been following the principle laid down by Dr. Hare—that of the extended and slightly-flexed head. On the first indication of failing respiration the administration of the anesthetic is instantly suspended and the wound protected, if abdominal, a broad piece of gauze is laid over the intestines under the incision. An assistant steps upon the table and takes one of the patient's knees under each arm, and thus raises the body from the table until it rests upon the shoulders. The anesthetizer, in the meantime, has brought the head to the edge of the table, where it hangs extended and slightly-inclined forward. This position, shown in the accompanying cuts, is similar to that described by Dr. Hare and resembles that taken by the runner when he is breathing hard. The patient's clothing is pulled down under her armpits, completely baring the abdomen and chest. The operator, standing at the head, institutes respiratory movements as follows: inspiration by placing the open hands on each side of

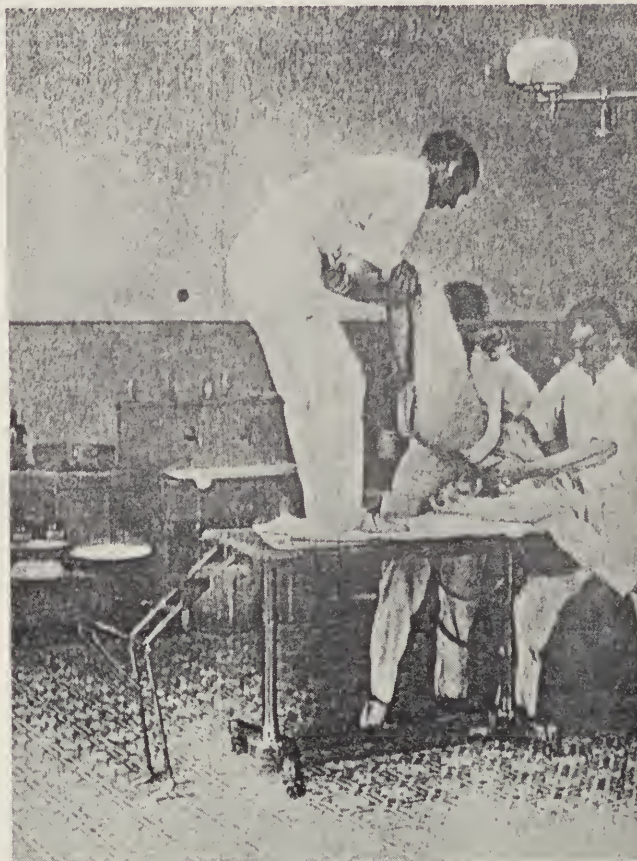


FIGURE 1: INSPIRATORY MOVEMENT. (Dr. Kelly is manipulating the chest.)

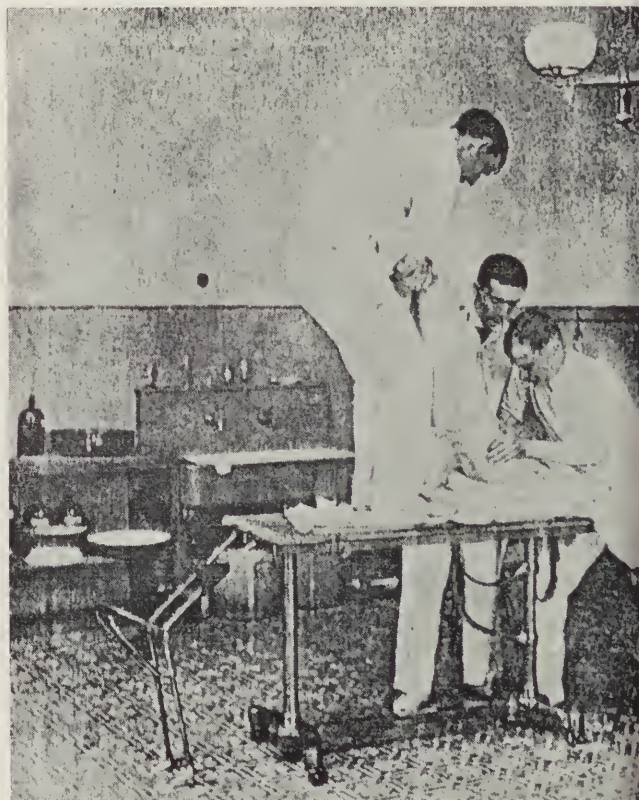


FIGURE 2: EXPIRATORY MOVEMENTS.

the chest posteriorly over the lower ribs, and drawing the chest well forward and outwards, holding it thus for about two seconds (Figure 1); expiration, reversing the movement by replacing the hands on the front of the chest over the lower ribs and pushing backwards and inwards, at the same time compressing the chest (Figure 2). The success of the manoeuvre will be demonstrated by the audible rush of air in and out of the chest.

"The heart and pulse should be constantly-watched. As respiratory movements are continued, a little flickering pulse wave will be observed at the wrist, which shortly becomes faint and regular, and gradually increases in strength. From 10-30 of these acts of induced respirations will usually suffice to excite voluntary respiratory movements, which begin with short jerky, gasping breaths, becoming louder and then regular. The movements must then be timed to suit the natural efforts. As the depth of inspiration increases, the color slowly returns, the pupils contract and the danger is past. In women with contracted, fusiform chests, (tight lacers), this procedure is not available; in such cases respiration should be induced by placing one hand on the lower third of the sternum, and the other on the back opposite the first, and alternately squeezing the chest and relaxing the pressure when air

will be audibly forced in and out, and the patient revived as by the previous method; it also fails in an old rigid chest."

A closing question for consideration: Could the reason for his success in 15 cases be that both of these methods provoke simultaneous extensive cardiac massage and artificial respiration? ☐

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Carotid Endarterectomy in a Small Community Hospital: A Team Approach

By JACK KUSHNER, MD; GARY RICHARDSON, MD and PETER SCHILDER, MD

This paper is from Anne Arundel General Hospital, Annapolis, MD. For reprint and other data, contact Dr. Kushner at 20 Ridgely Ave., Annapolis, MD 21401.

Introduction

What is the current status of surgery on the carotid artery in your community hospital? This challenging question was recently raised in an article by Easton and Sherman.¹ Whereas previous reports²⁻⁴ have demonstrated an acceptable mortality rate and a low complication rate, these authors have reported an operative stroke rate of 14.5% and a mortality rate of 6.6%. These alarming rates were also discussed at the recent meeting on *Correctible Causes of Cerebral Ischemia* in Chicago. This stimulated us to research and analyze our results so that we could learn just how our small community hospital was faring in this field.

The Anne Arundel General Hospital is a 220-bed community hospital in Annapolis, MD. Although the medical staff consists of 160 physicians, only three specialists deal regularly with the surgical treatment of cerebrovascular insufficiency. All of the patients were evaluated by a neurologist and a neurosurgeon; the carotid artery surgery was done jointly by a neurosurgeon and a vascular surgeon. Each specialist made a definite and distinct contribution, and the results, which are to be reported, justify this team approach.

Method

A retrospective study was done on 35 consecutive patients who had carotid artery surgery from 1973-78. Of this group of patients, 20 were men and 15 were women. Although the Anne Arundel General Hospital serves a racially-mixed community, only one of the patients was black; all of the other patients were white. The majority of the patients were between 55-70 years of age. There were five patients in the group who were older than 80 years of age. The patients have been followed from only a few months to as long as 48 months.

Indications

The patients for carotid endarterectomy were categorized into three major groups. The first group included those patients who had a documented transient ischemic attack of either or both the cerebrum or the retina. This was the most frequent indication for surgery. The neurological history and the physical examinations had to be supportive of the diagnosis. We felt that it was important that no neurological deficit was present at the time of surgery. The second group of patients were those who suffered a frank stroke, but who recovered significantly over the ensuing six weeks. Five patients from the above two groups of patients had a second operation on the contralateral carotid artery six weeks after the initial surgery. The decision to operate on the contralateral artery was usually based on a marked stenosis observed at the time of angiography. Since these patients had suffered either a stroke or a transient cerebral ischemic attack, surgery on the uninvolved side was felt to be justified. The last group of patients included those who were found to have an asymptomatic carotid artery bruit and who were found to have a carotid artery lumen of only 1 mm.-2 mm. Only three patients were in this controversial category.

Surgery was not recommended for a patient with an evolving stroke or a stroke in progression. Emergency surgery was not performed on any patients with a totally-occluded artery and a severe neurological deficit.

Preoperative Evaluation

All of the patients were examined by both a neurologist and a neurosurgeon. In the majority of the patients, a spinal tap was done to be certain there was no subarachnoid hemorrhage.

The CAT scan of the brain replaced the nuclear brain scan and gave immediate information about the status of the brain and the presence of a cerebral infarction. Although angiography was routine, there was no standard angiographic protocol or format. Most of the patients were studied by the Seldinger Technique or the retrograde femoral artery route. Some patients had such extreme arteriosclerosis that no catheter could be introduced through the femoral artery into the aortic arch. In a few patients, the catheter was inserted into the aortic arch via the brachial artery or through the translumbar approach. Occasionally, the retrograde brachial arteriogram was the best arteriogram that could be obtained.

Operative Technique

Preoperatively, venous and arterial lines were inserted. Radial arterial pressure was constantly recorded and the electrocardiogram was monitored on a Hewlett-Packard aggressive treatment cart. After the patient was anesthetized, a pad was placed under the shoulders and the head was elevated in a semi-Fowler's position.

The carotid artery surgery was done by making an incision along the anterior border of the sternocleidomastoid muscle. The common carotid artery was identified and umbilical tape was passed around it with a Rumel clamp. The artery was skeletonized and 1% Xylocaine was injected around the carotid body. Tapes were passed around the external and internal carotid arteries. A 2-0 silk tie was passed around the superior thyroid artery and the hypoglossal nerve was isolated. A segment of the external jugular vein was isolated and removed so that it could be used later for a vein patch graft; 5,000 units Heparin were given intraarterially into the common carotid artery. The common carotid artery was clamped momentarily while the Javid bypass shunt was inserted into the internal carotid and common carotid arteries. The shunt was used in all cases and no EEG recording was made. No stump pressure was recorded, although the internal carotid artery back-flow was noted. When the shunt was in place, the endarterectomy was performed. The artery was then irrigated with saline. Then the arteriotomy was closed with a 6-0 prolene suture. A Satinsky clamp was used after the Javid bypass shunt had been removed so that the rest of the artery could be closed. Protamine (50 mgm.) was given intravenously after the artery was sutured. The wound was closed in layers; no drain was left in place.

Results

Forty carotid endarterectomies were done on 35 patients. To date, 33 of the 35 patients are alive. One patient who had a frank stroke had a carotid endarterectomy six weeks after his stroke. At the time of surgery, he was thought to have recovered, even though he had a unilateral hyper-reflexia. During surgery, the patient had another stroke and was rendered aphasic and hemiplegic. Four weeks later he expired. One patient died of a myocardial infarction six months after having carotid artery surgery; 38 carotid endarterectomies were done without any significant or permanent neurological deficit. Most of the patients were discharged one week after their carotid artery surgery.

In the high-risk frank stroke group, there were four patients who had carotid endarterectomies. Six weeks following a stroke, one patient underwent a successful carotid endarterectomy. He was discharged one week later. The contralateral carotid was operated upon six weeks later. After two months, he resumed serving as a judge in the local court.

One patient had a stroke during angiography. Despite immediate surgery, she did not improve and still has a permanent neurological deficit.

Two patients developed a wound hematoma which required surgical evacuation. These patients did well subsequently. There

were no wound infections in any of these patients. Four patients had a mild hypoglossal nerve paresis, but these patients improved in a few weeks.

Three patients developed a serious cardiac arrhythmia. One patient had a permanent cardiac pacemaker inserted prior to carotid artery surgery and two other patients required pacemaker insertion in the postoperative period.

Discussion

Examination of Table 1 reveals that 35 patients had 40 carotid endarterectomies. Only one patient had an operative related stroke and subsequently expired four weeks later. This single patient was from the high-risk stroke group. Even though he had a residual unilateral hyperreflexia six weeks after his stroke, we felt that he should have a carotid endarterectomy before he had a second, more devastating stroke. The unfortunate result in this single case was no reason to deny other patients the life-saving advantages of having carotid artery surgery. Three other patients in this same group did well.

One other patient was listed as having a permanent neurological deficit following surgery. This patient developed her permanent neurological deficit during angiography. This complication was not attributed to the surgery. She was taken to surgery immediately after the arteriogram. Despite the use of a shunt and a vein patch angioplasty, we were not able to reverse her neurological deficit.

Mention should be made of other non-invasive methods of evaluating carotid artery stenosis. Ophthalmodynamometry was done on most of our patients. Although this test can suggest the diagnosis if it is positive, this certainly does not indicate the absence of an ulcerated plaque if it is negative. To date, we have not used phonoangiography or oculoplethysmography because we are not convinced that these tests will add anything of substantial value. Negative examinations with these tests could easily overlook an ulcerative carotid plaque which emits emboli to the brain.

Although we are reporting the results of 40 carotid endarterectomies, a stroke mortality rate of 2.5% is in keeping with the best of other published series. We feel that our team approach has contributed significantly to the results which have been obtained. We would urge other small community hospitals to adopt a similar policy.

Summary

A retrospective study of 40 consecutive carotid endarterectomies was done to determine the stroke rate and the mortality rate in a 220-bed community hospital. Only one patient had an operative related stroke and subsequently expired. The low stroke mortality rate of 2.5% is attributed to the team approach to the problem of carotid artery surgery.

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TABLE 1: Operative Morbidity and Mortality after Carotid Endarterectomy

Clinical Condition	# Patients	# Operations	Transient Deficits	Permanent Deficits	Deaths
1. Frank stroke	4	5	0	2	1
2. Transient Ischemic Attack	28	32	8	0	0
3. Asymptomatic Bruits	3	3	1	0	0
4. Total	35	40	9	2	1

Three patients had carotid artery surgery for an asymptomatic carotid artery bruit. One of these patients had a transient hemiparesis after surgery which lasted for one hour and then completely cleared. We felt that these particular patients were very likely to develop a stroke in the future because their carotid artery lumens measured 1 mm.-2 mm. The decision to operate on these patients was influenced by Javid's study of the natural history of carotid atheromas.⁵

Table 2 indicates that 33 patients are still alive. One patient died four weeks after his carotid artery surgery. The other patient died six months after a myocardial infarction.

TABLE 2:

Follow-up on Patients After Carotid Endarterectomy

Time Followed in Months	No. Survivors	No. Deaths
0-12	12	2
13-24	12	
25-36	5	
37-48	4	

The advantages of a complete aortic arch study and four vessel examination of all the extracranial and intracranial vessels are well-known. When the diagnosis is apparent on the initial aortic arch injection, and when the carotid stenosis is severe, we are not eager to selectively insert a catheter into that artery for further injections. One of our patients did have a stroke during angiography and, since then, we have not been as insistent on obtaining complete views of the intracranial vessels. We are aware of the pitfalls and possible errors with this approach, but we feel that our results thus far justify this flexibility.

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Editorial

Teamwork as an approach to carotid artery disease is both logical and necessary for good patient care. Carotid artery stenosis is a symptom of generalized arteriosclerotic peripheral vascular disease which may affect multiple body systems.

The appropriate leader of this team is neither the neurologist, neurosurgeon nor the cardiovascular surgeon who so often admit these patients. The real leader should be an internist or cardiologist who has the capacity to take a multi-system approach to this problem.

Acute stroke units, as well as many research units, have documented the high incidence of serious medical problems in patients presenting with TIAs and stroke. Most patients, whether approached medically or surgically, die from acute coronaries within the first five years of follow-ups. Large numbers of significant arrhythmias are picked up by continuous monitoring and a good percentage of acute silent MIs present as strokes. Anemias, uremias, vasculitides and endocrine disturbances may precipitate cerebrovascular ischemia. Seizure disorders, brain tumors and subdural hematomas may mimic this process.

Perhaps the stroke/mortality related to four vessel angiography and carotid surgery would be greatly reduced if patients were selected more carefully. The need for the surgical approach would probably be significantly-reduced if the medical problems were appropriately-treated.

The degree of carotid stenosis alone may not be the most important factor in determining patient prognosis. Perhaps cardiac output is more important and perhaps if we diagnosed bradycardia first, we wouldn't need the endarterectomy, but just the pacemaker.

Stroke mortality rate may also be reflective of the frequency that an individual procedure is performed by the operating surgeon. Neurosurgeons have shown quite readily that aneurysm surgery should be approached in large centers where the procedure is done with great regularity by specific teams who can gain great expertise in this type of surgery. I personally suspect that arch aortography and carotid endarterectomy are no different. The figures presented by Drs. Kushner, Richardson and Schilder reveal that, if evenly-split, no surgeon did more than four of the procedures in that hospital per year. In Easton and Sherman's paper, if the procedures were distributed evenly, there was no better frequency of surgery by individual surgeons. Perhaps teamwork should go one step further to include large hospital referrals.

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Clinical Biofeedback

By JESSE RUBIN, MD

Abstract

Biofeedback is a new and promising clinical tool in the treatment of several disorders including tension and migraine headache, anxiety states and psychosomatic disorders. The history and basic assumptions behind the use of biofeedback is given and its current clinical status with regard to a number of symptoms is defined. Specific clinical procedures used by the author are described, as are some of the limitations and difficulties inherent in the therapy.

Introduction

Biofeedback has been defined as, "The use of monitoring instruments (usually electrical) to *detect and amplify internal physiologic processes* within the body, in order to make this *ordinarily unavailable* internal information *available* to the individual and literally to feed it back to him in some form . . . The clinical importance of this is that utilizing such organ-specific artificial feedback, with continued exposure and practice . . . there is evidence that individuals can . . . *bring under partial conscious control* particular bodily functions that ordinarily are not subject to conscious control (like heart rate and blood pressure, for example) or, which ordinarily are under only minimal conscious control, like tension in the frontalis and occipitalis muscles."¹ (italics mine)

Biofeedback therapy may thus be thought of as the use of electronic equipment to extend the patient's proprioceptive and enteroceptive capacities, thereby permitting (or encouraging) him to change specific targeted functions in a physiologically desirable direction.

Much of this extension of sensorium involves smooth and striated muscle. Normally, we have only very crude information about the state of our smooth muscles, except in cases of extreme deviation from usual tension-relaxation cycles. Even in our striated muscles, we are often aware of only the *effects* of tension, but not of the state of tension itself. (As for example, in tension headache and neuraesthenic exhaustion.) There are also physiologic functions *not* connected with smooth or striated muscle which

can be monitored and fed back to individuals.

Such functions include galvanic skin response, peripheral blood flow (as measured by temperature) and electroencephalogram. Indeed, it is now possible to construct biofeedback equipment for most measurable physiologic parameters, given the money and technical resources.

That we can simply measure these parameters is nothing new. Electromyography, electroencephalography, electrocardiography and so on have been part of the medical diagnostic armamentarium for some time. What *is new* is the idea that information derived from such monitoring devices can be fed back instantaneously and continuously to a patient in order to help him control and shape the physiologic function monitored. Indeed, until about 1967, it was generally assumed by the medical and scientific community that voluntary control, and the capacity to learn new behaviors, was possible only in those areas of functioning which are 1) supplied by the "voluntary" nervous system, 2) effected by striated muscles and 3) subject to the command of the "conscious mind."

However, in 1967, Miller and Di-Cara² reported that 21 of 23 curarized rats were able to learn to increase and decrease their heart rate by as much as 25% when such changes were immediately rewarded by electrical stimulation of the medial forebrain bundle (a pleasure center). Though subsequent attempts to reproduce this specific experiment have failed,³ the report spurred a great deal of interest in the study of "visceral (autonomic) learning." It was reasoned that if animals could learn to control their heartrate in the absence of skeletal muscle activity (they were curarized), then perhaps human beings suffering from a variety of psychosomatic, medical and psychiatric disorders could similarly learn to change their visceral behavior in a physiologic or healthy direction.

Both before and after Miller's provocative findings, a number of researchers were utilizing instrumental monitoring and feedback techniques in animals and humans

to test both the limits of the technique and the possible therapeutic uses of it. Such studies proliferated sufficiently to justify the annual publication, beginning in 1969, of a collection of studies involving visceral learning and biofeedback.⁴ During the past two or three years, the field has moved from basic research through clinical and applied research into the area of practical clinical application.

As with any new therapeutic modality, biofeedback has been the subject of a core of steady and reliable research, along with dramatic, overly-enthusiastic claims⁵ on the one hand, and by tough but careful criticism⁶⁻⁷ on the other.

This article presents a cautiously optimistic view of the current status and future promise of biofeedback therapy in clinical medicine.

Antecedents

Biofeedback therapy derives from three main sources. They are:

1. Operant conditioning: Most of the best animal and human research in biofeedback has been done by behavioral psychologists using the principals of operant conditioning first developed by B.F. Skinner.⁸ Roughly, it may be said that operant conditioning utilizes behaviors which naturally occur in the subject's (animal or human) repertoire and selectively reinforces them positively or negatively (i.e., by rewards or punishment) in order either to augment or diminish (extinguish) these behaviors.

For example, by feeding a pigeon a pellet of food whenever his natural movements roughly deviate to the right, the pigeon will soon begin approximating walking in a clockwise circle. Food rewards are then given only for movements which more finely approximate circularity. This process is called shaping. Applied as a therapeutic technique in humans, it is called behavioral, modification therapy. As Ferster has written,⁹ "The dramatic experience of conditioning an animal, shared alike by novice and professional, in which the experimenter by contacting the animal only through a button which operates the food-dispensing mechanism increases the frequency of a performance and shapes it into a

new complex form all in a matter of a few minutes, is one of the most important sources of belief that behavioral psychology can contribute to the solution of human problems."

Even prior to the development of biofeedback techniques, operant conditioning methods were used to investigate the processes of visceral learning. Therefore, once appropriate monitoring instruments for various physiologic functions were developed, feeding back instrumental readings in the form of rewards or punishment fits easily into the operant conditioning model. For example, if a rat changed his heart rate, he would receive a pleasurable stimulation to the brain. This was the feedback mechanism used in Miller's classic experiment. Transposed into work with humans, change in heart rate would be reinforced by a feedback signal such as a musical tone. The reward for the human is not electrical brain stimulation, but a knowledge of mastery over one's own heart rate. Thus, most behavioral psychologists working in the field view biofeedback as simply one aspect of behavior modification therapy.

2. Medical relaxation treatments: At about the turn of the century, Dr. J.H. Schultz, a German physician, following work done by Oscar Vogt, developed a complex and elegant form of relaxation therapy for psychiatric and psychosomatic disorders. This treatment, which came to be called Autogenic Therapy, involved frequent practice by the patient of a standard set of "autogenic" phrases—such as, "My arms are getting heavy" and "My legs and arms are warm," "It breathes me."

In order to induce a state of relaxation, and a concomitant reduction in nervous tension and anxiety, these phrases were daily practiced by the patient. Proper posture, passive (as opposed to active) concentration on the phrases and capacity to make mental contact with the bodily parts involved in the phrases were deemed essential for success in autogenic therapy. Autogenic therapy remained an obscure treatment modality in the United States until recently. Schultz's work has been carried on by his pupil, Wolf-

gang Luthe, who has written a definitive, six-volume work on Autogenic Therapy.¹⁰

About 20 years after Schultz began his work, and apparently independent of it, the American psychiatrist, Jacobson, developed other methods to achieve relaxation, which he first called progressive relaxation and later called "operational control."¹¹ Though the techniques of Jacobson and Schultz differ, some basic assumptions and goals are the same. Both assume that mental tension and physical tension are inseparable, and that if physical tension can be relieved, mental tension simply will not occur. In a sense, they work from the outside in. This complements the psychoanalytic approach, which works from the inside (the mind) out, and which takes the position that if emotional conflicts are understood and resolved, then the physical sequelae of these conflicts (tension headaches, anxiety states, peptic ulcer, etc.) will be relieved.

Thus, the Schultz-Jacobson approach views tension and anxiety as a generalized, non-specific state which can often be treated (at least in the early stages) without regard to the specific content of the conflicts involved. Luthe, for example, feels that autogenic phrases initiate *general* health-oriented homeostatic mechanisms, and that *specific* mechanisms should be involved only later in therapy and with caution. Psychodynamic (psychoanalytic) psychiatry, on the other hand, places its emphasis on the specific of the conflicts which underlie anxiety.

One psychoanalyst, however, explicitly recognized that bodily states, particularly muscle spastic states, were an integral component of emotional conflict. Wilhelm Reich wrote extensively about the somatic expression of a number of characterologic and neurotic problems in the 1920s and the 1930s. His investigations led him eventually out of the mainstream of psychoanalysis and medicine; however, along with Schultz, Luthe and Jacobson, his emphasis on the somatic and muscular correlates of disordered psychophysiology constitute an important source of clinical data for biofeedback therapy.

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Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



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(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.

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3. Objective investigation of meditative states: In the 19th Century, there were isolated attempts by Western physicians to understand the sometimes extraordinary feats and trance-like states of Yoga and Zen masters. However, truly useful data concerning these phenomena awaited the development of modern instrumentation. In recent years, a number of studies⁴ have uncovered potentially useful information for practitioners of Western medicine. Important among these is Wallace's study of the physiology of meditation.¹³ Wallace studied experienced meditators and found that during meditation, a number of their physiologic functions altered in the direction of relaxation and diminished sympathomimetic response. These changes persisted for several hours after the meditative experience.

Biofeedback Therapy: Basic Assumptions

The following assumptions are the basis of a rational approach to biofeedback therapy. They are adapted from Gaarder.¹⁴

1. Many medical, psychiatric and psychosomatic illnesses are characterized by what may be termed either an anxiety state or a high nervous tension level or an inefficient use of psychic and somatic energy or an unhealthy and persistent high arousal level.

2. Each person has his own (probably constitutional) pattern of response to chronic high tension levels, which occurs in two steps. First, there is an intermittent fluctuation in certain physiologic parameters into and out of normal range (labile blood pressure, early tension headaches, gastrointestinal spasm of a preulcerous variety, intermittent anxiety attacks); second, there is a fixed psychosomatic state of ill health (essential hypertension, peptic ulcer, chronic tension headache, chronic severe anxiety state).

3. Less reactivity to stress and lowering of the arousal state (or tension level) may prevent or alleviate these difficulties. More specifically, it would be expected that shift from a predominantly trophotropic response (high-stress, hyperarousal, predominantly sym-

pathetic) toward a predominantly trophotropic response (tranquility, lower arousal, decreased sympathetic activity) would be useful to "high stress reactive" patients. The trophotropic response has been nicely recast and renamed for clinical purposes by Benson¹⁵ as the "relaxation response." The relaxation response is characterized by diminished oxygen consumption, diminished respiratory rate, diminished heart rate, increase in EEG alpha waves, increase in galvanic skin response, decreased muscle tension and possibly decrease in blood pressure.

4. Subjectively experienced heightened arousal has somatic correlates which can be monitored. Green and Green¹⁶ hypothesize that, "Every change in the physiologic state is accompanied by an appropriate change in the mental-emotional state, conscious or unconscious, and, conversely, every change in the mental-emotional state, conscious or unconscious, is accompanied by an appropriate change in the physiologic state." (This may not be true for all people. For example, Raskin¹⁷ reported one patient who was able to achieve deep muscle relaxation, but reported that he still felt subjective anxiety. However, based on the author's and others' clinical experience, for the vast majority of the population, the assumption holds true.)

5. "Visceral learning" does occur. That is, if people are fed appropriate information about the

functioning of their smooth and striated musculature, circulatory functioning or brain waves, they can learn to change and control them, to some degree.

Current Status of Clinical Biofeedback

With the transition of biofeedback from the research to the clinical setting, reliable instrumentation has become available on a commercial basis to physicians, and a clinical biofeedback literature has come into existence. (Unless otherwise noted, observations in this section generally follow material presented in Birk.¹) In general, biofeedback is used in two somewhat overlapping but distinct ways. First it is used as a direct attempt to normalize a specific "abnormal" or symptomatic function as illustrated in Table 1. (Some of these applications are still experimental. Table 1 is intended as illustrative of the approach in this first group of patients, rather than as a comprehensive classification of clinical indications for biofeedback.)

Second, biofeedback is used in a more general, less specific way, to help patients shift from a predominately ergotropic (anxiety) response to a predominately trophotropic (relaxation) response as a way of dealing with stress. The important therapeutic gain is twofold. First, the shift itself is beneficial; second, the patient's sense of mastery over his psychophysiologic condition in the face of painful symptoms is helpful. In this

Table 1

Symptom	Abnormal Function	Feedback Mechanism	Desired Change
Tension Headaches	Scalp and facial muscle tension	Forehead and other muscle, EMG	Relaxation of musculature
Pure migraine	Vascular alterations	Temperature (peripheral blood flow)	Prevention of contraction-dilation cycle
Mixed Tension-migraine headaches	— Combination of both of the above —		
Cardiac arrhythmias	Irregularity of pulse	Pulse	Regularization of pulse
Psychosomatic neck pain	Spasm of neck and shoulder muscles	Trapezius, frontalis, and masseter EMG	Relaxation of muscles
Epilepsy	Abnormal brain waves	EEG	Regularization of EEG

second group, treatment indications include anxiety states, phobic states, sleep onset insomnia and a variety of psychosomatic illnesses, particularly in their early stages.

Specific symptoms which have been treated with biofeedback include:

Headache: Tension and migraine headaches, in pure or mixed forms, are the best established indications for biofeedback therapy.¹⁸ The usual procedure is to begin with relaxation instructions along the lines suggested by Schultz or Jacobson (see above), and to couple these with biofeedback sessions utilizing frontalis electromyographic feedback. During this procedure, the patient hears clicks or tones whose frequency or pitch is directly related to the tension level in the frontalis muscle. The frontalis is accessible, is directly involved in headache production and is also a good reflector of general muscle tension throughout the body.

For most tension headache patients, general deep muscle relaxation and frontalis biofeedback therapy is all that is necessary. If subjective anxiety is present with the tension headache, electromyographic feedback may be followed by alpha-theta electroencephalographic feedback therapy. For migraine and mixed headache patients, electromyographic frontalis feedback must be followed by training on temperature (peripheral blood flow) control.

In the latter procedure, the patient receives auditory or visual feedback which reflects the temperature in his hands, either absolutely or as compared to the temperature of his forehead. This, in turn, is a reflection of his state of peripheral circulation (vasodilatation-warm). As the patient learns through the feedback therapy to raise the temperature of his hand at will (by up to 20°F.), he is able to prevent or abort the vascular component of migraine headaches. Diamond reports 80% success with pure migraine patients and 50% success with mixed and tension headaches. Cluster or allergic headaches thus far have not responded to biofeedback therapy.

Cardiovascular problems: The use of biofeedback in the treatment of cardiac arrhythmias and Raynaud's disease is less well-established, but shows promise. The training procedures vary somewhat, but emphasize direct feedback of the physiologic target parameter. For example, with cardiac arrhythmias, the cardiac rhythm is fed back to the patient. In Raynaud's disease, the peripheral blood flow (temperature) is fed back. Fixed essential hypertension has been reported not to respond, but there is promise that hypertension in the early, labile stage may respond to biofeedback therapy. At this writing, instrumentation for direct blood pressure biofeedback is still limited to research settings, but temperature and GSR feedback, which are clinically available, show preliminary good results.

Epilepsy: Early work with electroencephalographic biofeedback in epileptic patients is promising, though it is too early to be firmly established in the clinical armamentarium, and must be used with great caution (see below).

Physical medicine and rehabilitation: Brudny¹⁹ and others have reported good results in the rehabilitation of patients with upper and lower motor neuron lesions in augmenting and retraining muscle groups previously paretic. He also achieved good results in patients with torticollis.

Psychiatric and psychosomatic indications: Although there has been a flurry or over-optimistic reports in the popular press over the past few years about the use of biofeedback to achieve mind control, tension reduction, creativity, etc. hard clinical reports on the use of biofeedback in psychiatric disorders are just beginning to appear.^{17,20-21} By and large, these reports show promising, but not spectacular, results.

In my opinion, difficulties are more due to the newness of the procedure and the need to develop and refine techniques than to any inherent problems in the basic assumptions. The use of biofeedback in anxiety states seems natural, since anxiety states are

almost always accompanied by some measurable and potentially controllable physiologic parameter, such as increased muscle tension, reduced peripheral blood flow or high frequency, asynchronous muscle tension, reduced peripheral blood flow or high frequency, asynchronous brain waves. However, since none of these constitute the anxious state (as muscle tension constitutes a tension headache, for example) biofeedback therapy is somewhat more complex, involving training for the relaxation response.

Sleep onset insomnia has shown some response to biofeedback treatment.¹⁷ Some unpublished reports²¹⁻²² indicate the usefulness of biofeedback for a variety of early psychosomatic conditions. The response here is mediated via the relaxation response, rather than via direct feedback of the physiologic parameter involved.

Prerequisite for Biofeedback Treatment

For biofeedback therapy to be effective in any of the clinical areas noted above, certain factors must be appreciated and incorporated into the treatment program. These are:

1. Psychophysiologic diagnostic survey and rational construction of biofeedback modalities.
2. Appreciation of strength of the reinforcer (feedback signal) and addition of other positive reinforcers. (That is, proper appreciation and incorporation of placebo effect.)
3. Frequency of the treatment and priority of the treatment.
4. Side effects.

Each of these will now be considered in some detail.

1. Psychophysiologic diagnostic survey. This concept follows Budzynski.²³ This derives from assumption two, under Therapy, "Each person . . ." We have all known patients who respond to nervous tension with functional gastrointestinal systems or clammy hands or rigid, tight, tremulous muscles or excessive sweating or other system-specific manifestations. Utilizing the monitoring capacities of our

various biofeedback equipment, we can target in on the physiologic systems which seem most reactive to stress.

For example, if we discover in a given patient that his hands stay warm during anxiety episodes, it would be useless to train him to increase his peripheral blood flow, because this aspect of his physiology remains "relaxed" even during stress.

An ideal complete psychophysiologic diagnostic survey is clinically unavailable now because techniques for continuous blood pressure and pulse monitoring, for example, are crude, prohibitively expensive and limited to a few experimental laboratories. Nevertheless, electromyography, electroencephalography, peripheral blood flow and galvanic skin response can be measured clinically.

Once a psychophysiologic diagnostic survey is done, the treating physician rationally devises a sequence of biofeedback treatments appropriate for the specific patient. For example, it may seem most useful to begin with electromyographic biofeedback and then to proceed to temperature training, followed finally by electroencephalographic training for alpha or theta. This, in fact, is our most common sequence at the present stage of clinical biofeedback therapy.

2. Recognition of the relative strength of the biofeedback signal as a reinforcer and incorporation of "placebo" effects: Part of the initial enthusiasm about biofeedback derived from animal experiments. It must be kept in mind that in these settings, experimental animals were rewarded with food or stimulation of pleasure centers in the brain, and conversely were punished for undesired performance with, for example, electroshocks. In the clinical setting, of course, our reinforcers for desired behavior are considerably weaker.

Clinically, there are three types of reinforcers, two short-term and one long-term. First is the feedback signal itself. When a patient is hooked up to an electromyographic biofeedback device and

hears clicks whose frequency varies directly with his frontalis muscle tension, he is motivated by his wish to master the art of relaxation toward diminishing the frequency of clicks. However, it must be remembered that this reinforcer alone has nowhere near the power of those used in animal work. Therefore, it is essential to add the second short-term reinforcer—a warm, positive attitude by the therapist. The third, long-term, reinforcer is the patient's hope that he may rid himself of an unpleasant and unhealthy condition, such as anxiety or headache. In addition, all these reinforcers must often work in conjunction with other forms of psychiatric or medical therapy.

Placebo effects in biofeedback have been a subject of controversy. Some studies have shown patients to respond as well if feedback signals are falsified⁷ and others⁶ present evidence that biofeedback effects are no better than placebo effects. My position is that biofeedback can provide necessary, but not sufficient reinforcers for the type of physiologic changes desired. Stroebe²⁴ has shown that if placebo effects are not discarded, but rather are utilized to create an air of mild, though not excessive, optimism, biofeedback treatment works optimally, and our own experience corroborates this. Biofeedback therapy, combined with mild encouragement, home relaxation practice (see below), and possibly other medical or psychiatric treatment modalities, can help significantly in the treatment of certain medical, psychosomatic and psychiatric disorders; but simply hooking a patient up to a biofeedback machine probably won't do much of anything.

3. Frequency and priority of treatment: Once the weakness of the reinforcers (reward and punishment system) in clinical human work is recognized, one can see that patient acceptance of the total biofeedback therapy program—office visits plus home practice—is essential. The patient must practice relaxation techniques conscientiously on his own twice a day (see below) and visit the clinic between

one and three times a week regularly for the first month of therapy. Lack of commitment to this program disqualifies a patient because it signifies considerably decreased chances of success.

4. Side effects and contradictions:²⁵ The relatively benign, non-invasive nature of biofeedback is most appealing. However, certain precautions with regard to side-effects must be observed.

In patients with hypothyroidism and diabetes, successful biofeedback therapy leads to a normalization of function, so that medication levels should be carefully monitored. If this is not done, and medications are kept constant, patients may have hypoglycemic or hyperthyroid episodes.

In patients with impaired cerebral bloodflow (in hypertensives, for example), training directed toward normotension may produce transient cerebral ischaemia.

Occasionally, patients with renal disease have reported kidney pain during biofeedback therapy. Although its meaning and mechanism are not clear, therapy has been stopped.

Cervical spine films should be done prior to instituting biofeedback treatment for torticollis, to assure that straightening of the cervical spine will not aggravate an existing lesion.

Although EEG feedback has been used in the experimental treatment of epilepsy, this should be done only by experienced physicians. Paradoxical responses, with increased seizure activity, are reported.

The possibility exists that suggestible patients may become hyper-suggestible in the relaxation state, though this is by no means proven. To avoid this, the self-mastery and self control aspects of biofeedback should always be emphasized. Also, care should be taken at the end of sessions that patients are back to normal alertness. In an experimental population of college students, Green²⁶ reports that during the first week or two of electroencephalographic feedback, a few subjects felt sluggish, fatigued and nervous, but

these responses were only temporary.

Waste of the patient's time, energy and money are subtle, but none of the less potential, side effects of biofeedback, as of any, therapy. Care must be taken that patients not postpone or neglect indicated medical or surgical treatments.

On the other hand, biofeedback is useful in diminishing side effects of other treatments by reducing need for medication, especially in migraine and sleep-onset insomnia.

Description of Biofeedback Therapy

Our procedures generally follow from the assumptions and positions stated above. They are as follows:

Screening: Patients are referred for general anxiety states or for specific psychophysiologic conditions such as headaches, neurasthenia, psychophysiologic musculoskeletal reactions (neck or back spasm) or psychosomatic conditions associated with subjective anxiety (e.g., peptic ulcer). A history is taken, focusing especially such symptoms as subjective anxiety, peripheral coldness and other physiologic manifestations of psychosomatic disequilibrium. Age of patient and chronicity of symptoms are important. As with most medical treatments, the more recent the symptoms and the younger the patient, the better the prognosis. If the patient is accepted for treatment, he or she is told that the treatment is new and the methods are explained in detail. The vital importance of home practice and keeping office appointments is emphasized. In addition, the issue of passive volition (letting the change happen) versus active volition (trying consciously to make it happen) is discussed in detail.

At the next appointment, a psychophysiologic diagnostic survey is done. Baseline EMG from at least two sites, skin temperature (also from at least two sites) and EEG average amplitude and frequency are all recorded. These data are collected with the patient at rest and then under mild stress. The latter consists of a mental

arithmetic task or imagining a difficult or stressful personal situation.

Based on the history, diagnosis and psychophysiologic survey, a treatment regime is devised. We usually begin with some form of relaxation therapy combined with one of the feedback modalities. Sometimes formal psychotherapy is included.

The patient is instructed in the relaxation therapy chosen and is told to practice at home 15 minutes twice a day. This may consist of a simple instruction to try and relax and sink into the chair (or bed) in a comfortable position, to feel heaviness in the limbs and body, to try to eliminate intruding thoughts and to try and concentrate only on one's breathing. Frequently, however, more elaborate Jacobsonian techniques,¹¹ autogenic phrases,¹⁰ commercially available relaxation tapes²⁷ or tapes made by the therapist are added. If symptoms are severe, patients are required to chart symptom severity²⁸ twice a day. After a few days of home practice, results and problems are reviewed and patients are begun on the biofeedback modality chosen. Thus far, the commonest first modality used is electromyographic feedback.

Feedback sessions are conducted in a small, relatively quiet room whose lighting is kept rather dim. While therapy is done by prescription of and under the supervision of a physician, the actual sessions may be conducted by a physician, psychologist or nurse-therapist. A comfortable lounge-type chair is used by the patient. Sensors from the EMG machine (for example) are attached to the patient and a feedback modality agreeable to him is chosen from among those available on the machinery (clicks, tones or static). These feedback modalities reflect directly the amount of muscle tension. Common sites for recording include frontalis, masseter, trapezius and forearm extensors.

Theoretically, feedback can be obtained from any muscle group in the body, and it is possible to monitor and feedback from four different sites during the same feed-

back session. Auditory tone feedback is supplemented by a visual display meter. At the beginning, middle and end of each session, one-minute averages of electromyographic activity are obtained and recorded by the therapist. It is explained to the patient that the feedback is a direct indicator of general muscle or bodily tension. Patients are instructed to attend only to the relaxation instructions and the feedback noise.

When intruding thoughts occur (as they always do), the patient is told to take a detached attitude as of watching a movie, to let the thoughts drift past and then to return to the relaxation instructions. When autogenic phrases or phrases derived from the relaxation tapes are used, the patient is always reminded to take a passive attitude and let the relaxation occur, rather than actively to **make** it occur. He is also instructed to take a passive attitude towards the auditory feedback itself; that is, he is to allow it to diminish rather than actively to **make** it diminish. When the desired feedback occurs, additional reinforcers (rewards) are given in the form of warm praise from the therapist. If blocks (plateaus or increasing tension) occur, the therapist tries to observe tension points or asks the patient about them.

When the patient masters the electromyogram (on the Autogenic Systems Incorporated EMG 1500 feedback machine which we use in our program, this occurs at approximately .75 microvolts), other reactive systems are frequently introduced, so that the patient may, for example, first relax on the EMG, then learn relaxation of his cardiovascular system by temperature control and finally begin training on the electroencephalographic biofeedback device.

The basic approach on these modalities is the same, but some specifics vary. For example, while working on temperature control, the patient is encouraged to concentrate passively on phrases such as, "My hands and feet are warm" or to visualize their hands in a bucket of warm water. With electroencephalographic training, emphasis shifts to an emptying of the

mind, or to achieve a receptive, "open focus." Three of our patients independently and spontaneously reported that periods of decreased Hertz and increased amplitude on the EEG correlated with a peaceful sense of being aware of the ocean on a warm day.

In the first group of indications discussed above, the goal is to achieve feedback which demonstrates that the patient has voluntary control over the function monitored. Examples are voluntary, consistent achievement of a .75 microvolts (EMG), a finger temperature of 95° or voluntary maintenance of a steady alpha rhythm with eyes open. In the second group of patients described above, the goal is for the patient to respond to internal conflicts or external stresses of whatever source with a voluntarily-induced state of relative calm, tranquility and lowered arousal, i.e., the relaxation response.

After patients have some confidence in their capacity to relax psychophysiologically in the office and during the home practice sessions, they are enjoined to begin using the same relaxation techniques in their everyday lives, particularly when confronted with internal or external disturbing events.

Our team is currently treating approximately 20 patients, about half of whom suffer from anxiety tension states, and the rest from headache, psychophysiologic neck pain or early psychosomatic problems. We hope to report results of this series of patients in the future. At present, we can only present the possibilities and the limitations of this treatment modality.

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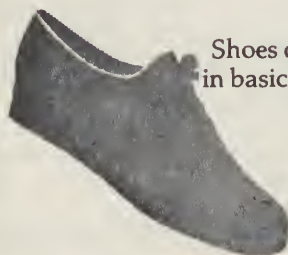
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Doctors in the News

Dr. Nakazawa in Office

Hiroshi Nakazawa, MD of Stevenson, formally assumed the position of President of Baltimore's St. Agnes Hospital Medical Staff recently. Dr. Nakazawa succeeds the



DR. NAKAZAWA

1978 Medical Staff President, Dr. Anthony Hammond of Ellicott City.

Dr. Nakazawa is a member of the Department of Surgery and the Emergency Physician Service, PA at St. Agnes.

Dr. Nakazawa received his Medical Degree from Chiba University School of Medicine in 1955. Following service as an intern in the US Naval Hospital in Yokosuka, Japan, he began additional intern training at St. Agnes, obtaining a residency in surgery which included one year of training at Bon Secours Hospital in Baltimore. Dr. Nakazawa completed his last year of residency as Chief Resident and began practicing general surgery in 1962.

Dr. Nakazawa's involvement in medical and community affairs includes his present position as member of the Board of Directors of the Maryland Foundation for Health Care, Inc. and Med-Chi. He is the

Vice President of Emergency Physician Service, PA, and has formerly served as a member of the Board of Directors of the Baltimore City Medical Society.

Dr. Nakazawa was a member of the Board of Directors of the Maryland Chapter of the American College of Emergency Medicine, and State Chairman of Med-Chi's Medical and Professional Care Committee. He has also served as Chairman of the BCMS Committee of Urban Medical Practice.

Dr. Nakazawa was the Physician Advisor of the Professional Standard Review Organization to St. Agnes Hospital, and is currently a member of the American Medical Association, Med-Chi, the BCMS and the American College of Emergency Physicians. □

Hopkins' Dr. Coyle Wins Major Pharmacology Prize

Joseph T. Coyle, MD, the young Johns Hopkins investigator who developed the first animal model for Huntington's Disease, an inherited brain disorder, has won the

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Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

Journal announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

1979 John J. Abel Award in Pharmacology. The award, given by the American Society for Pharmacology and Experimental Therapeutics, recognizes outstanding basic research by young scientists, and was presented at the Society's meeting in Dallas recently.

Also honored by the Society for outstanding research was **Thomas H. Maren, MD**, Graduate Research Professor of the Department of Pharmacology at the University of Florida College of Medicine in Gainesville. The Society honored him with the second Theodore Weicker Memorial Award, which recognizes sustained, distinguished contributions in pharmacology. Both Dr. Coyle and Dr. Maren are alumni of the Johns Hopkins School of Medicine. The first Weicker Award went last year to Hopkins Professor **Ernest Bueding, MD**.

Dr. Coyle, 35, has focused his work on chemicals in the brain which transmit messages from one nerve to another. These chemicals, called neurotransmitters, are the language by which neurons communicate among themselves and thus mediate the processes of thought, emotion, movement and sensation. Dr. Coyle's investigations of brain neurotransmitters led to the discovery of an animal model of Huntington's Disease, the tragic, inherited, neurological disorder whose most well-known victim was the late folksinger Woodie Guthrie.

While there is no current treatment to halt the progression of the disease, an animal model provides scientists with a means to study the processes in the brain which cause the jerking movements and mental deterioration characteristic

of Huntington's. Dr. Coyle discovered that a drug, kainic acid, when injected in microscopic amounts into the part of a rat's brain called the basal ganglia, upsets the ratio of neurotransmitters, causing Huntington-like symptoms and the same kind of cell death which occurs in Huntington's. This exquisitely-specific method of killing brain cells not only has provided a technique to study Huntington's, but Dr. Coyle has gone on to demonstrate other uses of kainic acid in inducing brain lesions. Scientists now use microinjections of kainic acid in other parts of the brain to study different neurotransmitter processes, thus widening understanding of basic neurochemical processes in various parts of the brain.

Dr. Coyle is also investigating nerve cell growth in the developing brain. Different types of nerve calls vary in the substances they use as neurotransmitters, and Dr. Coyle has focused on neurons which use dopamine as a neurotransmitter. Disturbances of the dopamine system within the brain are implicated in Huntington's, Parkinson's disease, schizophrenia, certain birth defects of nervous function, as well as childhood behavioral and learning disabilities of unknown origin.

"The mature nervous system is a poor model for understanding congenital nervous disorders," Dr. Coyle says, "because growing nerves may behave quite differently from mature ones, and each stage of nerve development may be affected by events occurring at earlier periods. For example, there is evidence that development of neurons may be guided during early brain growth by neurotransmitters re-

leased from neighboring cells."

Better understanding of how this important class of nerves develops is essential to learning how genetic defects or environmental agents may cause maldevelopment, and to future attempts to devise means of prevention or treatment, according to Dr. Coyle.

A 1969 graduate of the Johns Hopkins School of Medicine, Dr. Coyle is married to the former Genevieve Sansoucy, and they have three sons. Following an internship in pediatrics at the Johns Hopkins Hospital, he took a three-year fellowship at the National Institute of Mental Health with Nobel Prize-winner Dr. **Julius Axelrod**. He then completed a residency in psychiatry at Johns Hopkins. During medical school, he worked in the laboratory of Dr. **Solomon Snyder**, a former Abel Award-winner. Dr. Coyle joined the faculty as Assistant Professor in Pharmacology in 1974, working in the psychopharmacology group headed by Dr. Snyder. A practicing psychiatrist, Dr. Coyle also co-directs the Outpatient Pharmacotherapy Clinic at the Phipps Psychiatric Clinic. He was promoted to Associate Professor of pharmacology and psychiatry at Hopkins in 1978.

Dr. Maren, this year's Weicker Award winner, is a 1951 graduate of the Hopkins School of Medicine. He has demonstrated the important and ubiquitous role of the enzyme carbonic anhydrase in regulating fluid secretion in various body systems, including the brain, gastrointestinal tract, kidney and eye. In studies extending over 30 years, he has translated basic biochemical and pharmacologic observations to clinical treatment. □

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Hopkins Special Handgun Control Meeting

A special meeting on handgun control was held recently in the Turner Auditorium of the Johns Hopkins Medical Institutions in Baltimore.

Pete Shields, President and Chairman of Handgun Control, Inc., discussed the lack of progress on handgun control and what must be done to promote passage of appropriate national legislation. Johns Hopkins University President Emeritus Milton Eisenhower, who headed the National Commission on the Causes and Prevention of Violence, also spoke.

Shields became an advocate for handgun control following his son's murder in 1974 by San Francisco's so-called "Zebra Killer." He quit his job of 22 years at DuPont Chemical and joined the fledgling Washington, DC-based organization which he now heads. Handgun Control, Inc., is pressing for national legislation to control, but not ban, handgun use.

"Recognizing that there are 50,000,00 handguns out there in private hands, a ban is neither politically nor practically possible," Shields says, "but there is wide public support for measures which could effectively reduce the reckless and criminal use of handguns." Sen. Edward Kennedy (D-MA), Chairman of the Senate Judiciary Committee, is expected to introduce some handgun control measures soon.

Six bills to restrict handgun use in Maryland received strong support when Richard S. Ross, MD, Dean of the Hopkins School of Medicine, led a delegation of Hopkins doctors to Annapolis, where they testified on handgun control as a public health measure before the State Senate Judicial Proceedings Committee. Dr. Ross pointed out that firearms are the leading cause of death for non-white males aged 15-39. Edyth Schoenrich, MD, Associate Dean of the School of Hygiene and Public Health, added that "If there were some disease doing what handguns do, there would be an outcry to deal with it." A week later, all six bills died in committee, despite strong editorial support from the media. □

Fellowships Granted by the American College of Cardiology

The 9,500-member American College of Cardiology, national medical specialty society for specialists in cardiovascular diseases, has announced the names of physicians and surgeons recently admitted to Fellowship in the College.

Local governors, representing the College in each state and Canadian province have released the list of organizational members who recently have achieved the Fellowship category.

The new Fellows have fulfilled stringent membership requirements based on several years of practice and specialty certification. This evidence of qualification is augmented by recommendations from colleagues that show the candidate has attained a high standard in his/her community as a specialist or consultant in cardiovascular diseases or in an allied specialty.

The Bethesda-based American College of Cardiology was founded

three decades ago with the prime purpose of promoting and developing the life sciences pertaining to the circulatory system in health and disease. The College publishes a monthly journal, holds national conferences, designs and administers educational programs and encourages research.

In 1977, it opened a modern Learning Center and administrative headquarters in Bethesda to further its ongoing efforts in CME.

Bernadine H. Bulkley, MD, of Baltimore, ACC Governor for Maryland, announced that the following cardiovascular specialists in her geographic area have achieved the ACC's membership rank of Fellowship: Stephen C. Achuff, MD, Baltimore; Harris M. Kenner, MD, Bethesda and Keith M. Lindgren, MD, Takoma Park. □

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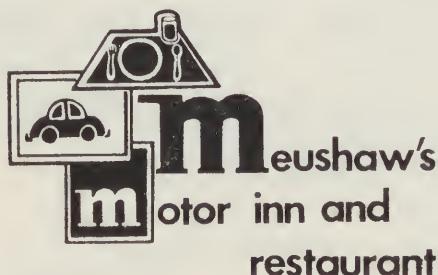
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Doctors Take Note

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The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

July 11-13, 12th Miles Internatl. Symp., Polypeptide Hormones. Chairman: Roland F. Beers, MD, PhD. For details, write or call Edw. G. Bassett, PhD, Symposium Coordinator, Miles Labs, Inc., PO Box 40, Elkhart, IN 46515; (219) 264-8460.

July 23-27, Educ. Diag. in Pub. Health and Med. Care. By Appointment, Practical Computer Reporting in Rad. On-going (Home Study) Postgrad. Course in Intern. Med. Seven Symposia (Home Study) Highlights of the Topics in Clin. Med.
(Home Study) Echocardiography: Theory and Practice.
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Sept. 6-7, Diag. Ultrasound in Ob/Gyn.; for details, call (301) 955-5880.

March 26-30, 1980, 3rd Anl. Natl. Symp. on Patient Educ. Papers being sought. Send one-page abstract by Aug. 1, 1979 to Ivan Barofsky, PhD, Hampton House 654, Johns Hopkins Univ. Sch. of Hygiene and Pub. Health, Balto., MD 21205.

The Hopkins Med. Insts. Dept. of Rad. and Rad. Sci. offers several courses in abdominal and obstetrical ultrasound. A

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Sept. 27-28, The High-Risk Infant: Who are They and What Happens to Them? Univ. Med. Campus. For further info. contact the Prog. of Cont. Educ. at (301) 528-3956.

Sept. 27-Nov. 1; Selected Topics in Family Prac., Part 1, (Thurs., 5:15-7:45 P.M.) Univ. Med. campus. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 5, Nutrition, College Park Campus Adult Educ. Ctr. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 10-12, Computer Tomography Symp.: Body CT and Neuroradiology, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 26-27, Practical Clin. Endocrinology, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

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Sept. 20-23, Contemp. Surgery: Univ. Ctr. or Community Hosp. by Fallston Genl. Hosp., Sheraton-Fontainebleau, Ocean City, MD. For details, call Nancy Miller at (301) 879-0500, ex. 3160. □

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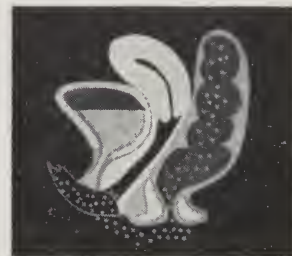
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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

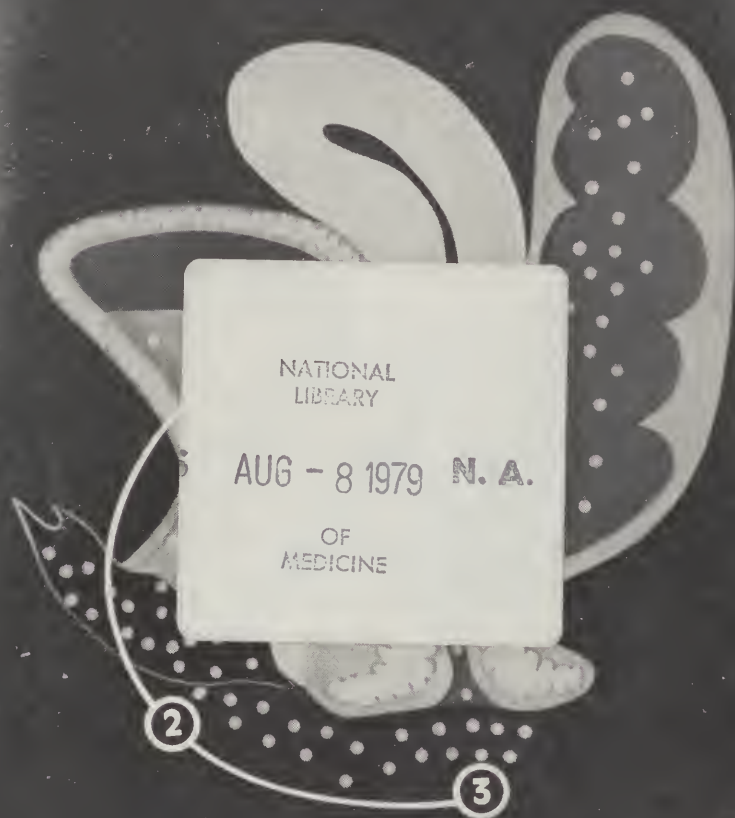


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Please see back cover.

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

AUGUST 1979

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MARYLAND STATE MEDICAL



Journal

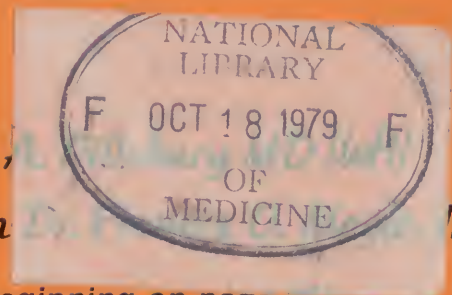


Changing of the Guard:

*Incoming Med-Chi President William Pillsbury
Receives Ceremonial Gavel of Office From Dr. Francis L. Pillsbury, Jr.*

(Dr. Pillsbury Profiled and Interviewed beginning on page 35)

Also inside: Transactions, p. 39



Physicians. Isn't It Time Your Career Had A Check-Up?



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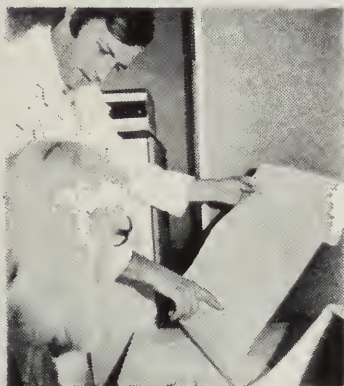
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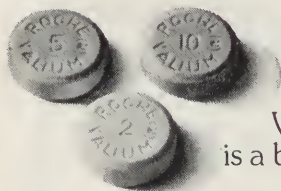
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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium[®] (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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EDITORIAL and BUSINESS OFFICE:
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201. Phone 1 (301) 539-0872.
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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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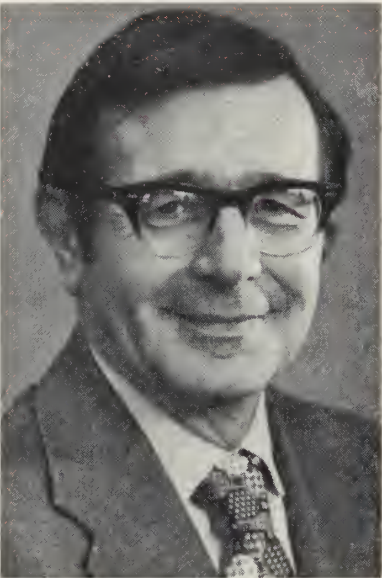
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WILLIAM A. PILLSBURY, JR., MD is the Faculty's new President. A profile/interview of him begins on page 35.
(This picture, as well as the cover photograph, is by Morton Tadder of Baltimore.)

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers' large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

The logo for the Pharmaceutical Manufacturers Association (PMA) consists of the letters 'PMA' in a bold, stylized, serif font. The 'P' and 'M' are connected, and the 'A' is separate.

Pharmaceutical Manufacturers Association
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The Open Forum

Heat Hazards

Thermostats in working areas of government office buildings will be turned to 80° this summer. Workers and people in general will be exposed to hot and humid weather conditions. It is important to plan for preventive programs against heat exposure. Three objectives of such a program are: 1) to prevent clinical disorders from the heat; 2) to prevent aggravation of existing medical conditions by the heat and 3) to maintain optimum health and work efficiency of employees.

Immediate action can be taken by:

1. assigning physically-less demanding tasks or tasks involving reduced heat exposure;
2. giving more frequent job breaks;
3. increasing the use of air-circulating devices;
4. providing shaded or heat adjusted rest areas;
5. allowing appropriate clothing;
6. training supervisors and employees in the medical effects of exposure to hot temperatures. There are four medical conditions which are the effects of heat exposure:

a. *Heat Exhaustion* is characterized by giddiness and fainting following standing or sudden change in posture or exercise in hot weather. It can be due to the peripheral pooling of blood and hypotension.

REMEDY: Replace perspired water and salt and remove the person to a cooler environment.

b. *Heat Cramps* occur in the skeletal muscles used in hot weather. The cramps are painful and spasmodic. The skin is usually hot and moist.

REMEDY: Replace perspired water and salt and remove the person to a cooler environment.

c. *Heat Stroke* is an emergency situation which results from prolonged exposure to hot temperatures. It is more serious than heat exhaustion or heat cramps. Persons with heat stroke often collapse without warning. They can be delirious, have convulsions or be in a coma. The skin is hot and dry, sweating has stopped. Body temperature can be as high as 104° to 106°F.

REMEDY: Immediately call ambulance and begin bringing the body temperature down as quickly as possible by applying a cold water bath with vigorous fanning. The person should be transported to a medical facility.

d. *Heat Rash* or prickly heat is a skin condition involving the sweat glands and prolonged ex-

posure to evaporated sweat. It is recognized as tiny red raised vesicles.

REMEDY: Wash and dry the skin thoroughly, apply talc or other drying agent.

7. The use of salt tablets without medical supervision is not recommended and
8. Preemployment physical exams should include an adequate history of tolerance to heat on and off the job. Heat tolerance and physical work capacity decrease with age.

Acclimatization to hot humid weather may take from a few days to several months. Persons must be alerted to the complications associated with hot weather and consider the preventive measures with which can be taken.

SUSAN R. GUARNIERI, MD, MPH

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CONRAD ACTON, MD, Editor

April Meeting

Amid the clatter of oyster shells, there was a larger than usual attendance at the April, 1979 regular meeting. Bivalves mean much to Baltimoreans!

Edmund Beacham, MD, Chairman of the Tellers, reported the election of four members to be our Councilors for the Med-Chi Faculty Council: *Ian R. Anderson, MD; John B. DeHoff, MD; William G. Helfrich, MD* and *Karl H. Weaver, MD*. Later it developed that BCMS is entitled only to three Councilors. There will be a run-off, as two were tied.

Reports

Ian R. Anderson, MD, Chairman of the Legislative Committee, briefly reported on outcome of bills of medical interest in the recent Legislature. Most of the major bills favored by the BCMS and Med-Chi were passed.

Paul Bormel, MD, President of the BCMS Foundation, reported that the Doctors' Day Dinner Dance was a success to the degree that \$1,400 was raised. He thanked the Auxiliary and the Society's staff for making it possible and worthwhile.

President Antlitz announced that Dr. Huang Chia-ssu, President the Chinese Academy of Medicine in Peking, will give a talk to the physicians of Maryland on May 13th. He is American-trained and also Editor of the English edition of the *Chinese Medical Journal*.

Walter Kohn, MD, was memorialized by John Hirschfeld, MD for long service in the community and devotion to his patients. Dr. Kohn died of a heart attack while giving CPR to a patient who collapsed in his office.

Dr. Fortuin Speaks

Exercise Therapy and Testing: Pro and Con was the evening's scientific subject. Nicholas J. Fortuin, MD, Professor of Medicine at Hopkins Medical School, started with a consideration of jogging. In his unstructured presentation, he noted that even the Blues were currently picturing a jogger in their advertisements as a symbol of health and quoted from the ancient Greek (I think Socrates) in favor of exercise. Why jogging is so much of a cult today is problematic and may rest on a number of factors. There is an admitted 'high' that jogging seems to bring along with second wind. Superstitions that "joggers never die" are passed on from jogger to jogger.

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Jogging has disadvantages too. Sudden death while jogging is not unknown. Orthopedic problems may be worsened or created. Possible mechanical injury by collision or fall may happen. Costs in time and equipment can often be considerable.

Dr. Fortuin considers stress testing very nonspecific. The Masters test is now quite obsolete. Submaximal and maximal testing with bicycle or treadmill can give useful information. In terms of ST changes he warned that false positives or negatives are possible. When compared with X-ray studies as to specificity, sensitivity and predictability, the stress test has its own validity. Normal and abnormal findings by either/both methods do not necessarily exclude the other's results.

Board of Directors Meets

The Board of Directors met Apr. 17th and had a long agenda which, after a brown bag type of supper, was largely repeated with the BCMS Delegates, Alternates and Councilors.

The Legislative Committee reported its evaluation of the actions taken by the State Legislature on bills of importance to Medicine. HB-637 was enacted requiring hospitals to provide staff privileges to non-medical doctors. The Committee urged writing to the Governor urging him to use his veto power. It poses legal complexities with JCAH accreditations, increased costs of care and mounting malpractice costs.

SB-780 would have prevented the HSCRC from controlling physicians. It was defeated. It is problematical, the Committee holds, whether the HSCRC has shown any actual effectiveness in controlling even hospital costs in Maryland. The only statistics supplied

are their own; therefore, the Committee recommends that an independent analyst be employed to determine whether or not there may have been any cost-savings attributable directly to the Health Services Cost Review Commission. This idea was referred to the Policy and Planning Committee, broadened to include the question of what more the BCMS should do with regard to the cost of medical care.

Myron M. Levine, MD, Chairman of the Public Health Committee, brought a request from his Committee for a name change. The designation of the Subcommittee on High School Athletics does not describe the scope of work done and could be turning off physicians who might participate. The title Subcommittee on Physical Fitness and Sports Medicine is in keeping with the broadening area of its actual activities. The Directors agreed and some publicity will be given in the *Newsletter*.

Dr. Heldrich Reports

Fred J. Heldrich, MD, Chairman of the Professional Education Committee, was present to give a lengthy report. He summarized membership response to questionnaires sent out in the *Newsletter*. These he could compare to replies regarding similar topics from several other medical societies. Some of them were larger, some smaller and some the same size as ours. After analysis, the Committee recommended five changes. These were for reduction of the number of meetings to five, deletion of the requirement for scientific program, (with or without Brownie points), for program of general interest, development of an alternate way of electing members and to ensure membership voice



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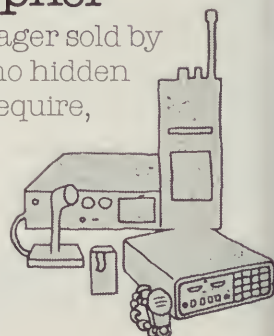
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in Society affairs with respect to submitting Resolutions. This was referred to the Bylaws Committee for implementation.

Dr. Antlitz Talks

President Antlitz reported that the Med-Chi Council was opposed to our Primary Care Study in principle and refused to assist its funding. Dr. Kassel reiterated that the study is for the protection and benefit of the private practitioners in primary care. Government planning of the funding for primary care is based entirely on statistics from hospital, institutional and governmental sources. This is because "data from the private sector is too hard to get". Our Primary Care Study is proposed to give the private sector an equal input to the planning process with the public providers and balance out the costing between them into a more valid and viable result. □

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Executive Director's Newsletter

August, 1979

GASOLINE

The Faculty has been active during the past several weeks in attempts to relieve the gasoline shortage for physicians.

SHORTAGE

It was instrumental in prior years in exempting physicians from the odd-even system of gasoline purchases. This method is also one used by the present Governor.

In addition, the Faculty has been able to obtain special allocations of gasoline supplies by working through component medical societies. The main problem in this area is that a storage facility must be obtained for these special fuel allocations.

Some societies have obtained regular gasoline stations to set aside one fuel tank for physician use, and gasoline has been allocated for dispensing to physicians under the control of the local medical society.

In Montgomery and Charles Counties, local station dealers are handling and storing the supply for physicians. In Prince George's County, two private hospitals have gasoline tanks available on their property and these facilities are being used.

Any inquiries on gasoline needs should be addressed to Michael A. Murray, Assistant Executive Director, at the Faculty office.

In a related area, the State Energy Office has advised its definition of an emergency situation:

"This will have to be left up to the good judgment of the service station owner. Obviously, if a person must be taken to a hospital or a car which has run out of motor fuel must be removed from the middle of a highway, gas should be supplied regardless of the date. Other similar emergency situations will arise and the service station owner will have to use his good judgment. The Governor has directed that when a service station owner acts in good faith in what he sees as an emergency, no one is to be prosecuted."

EXEMPTION TO HEATING AND COOLING CONTROLS

Physicians' offices are exempted from the requirement on heating and cooling controls for temperatures. The maximum winter temperature for heating has been set at 65 degrees F., and for summer, 78 degrees F.

CPT-4 Physicians and others in Maryland have purchased over 4,000 CPT-4s for use in billing insurance carriers, including those SUPPLEMENTS bills for Medicaid patients. Included in each of these books is a postal card to be mailed for obtaining supplements to the publication as they are issued.

The AMA has advised the third update to this is now available. They are mailed automatically if the postal card contained in the back cover of the CPT-4 book is mailed in. Physicians and others are reminded to do this.

SEMIANNUAL Material should have been received by all physicians on the MEETING Semiannual Meeting which is set for New Orleans, September 12 through 16, 1979. If you have misplaced this, copies can be obtained through the Faculty office.

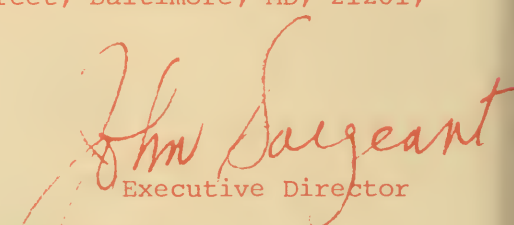
BUSINESS Business sessions for the Semiannual Meeting will be held on SESSIONS Saturday, September 29, 1979, at the Faculty Building. The House of Delegates is scheduled to commence at 2 PM that day.

Resolutions for consideration at this session must be in the Faculty office by the close of business on Friday, August 3, 1979. The Bylaws require that all such resolutions be received at least 8 weeks prior to the House of Delegates sessions.

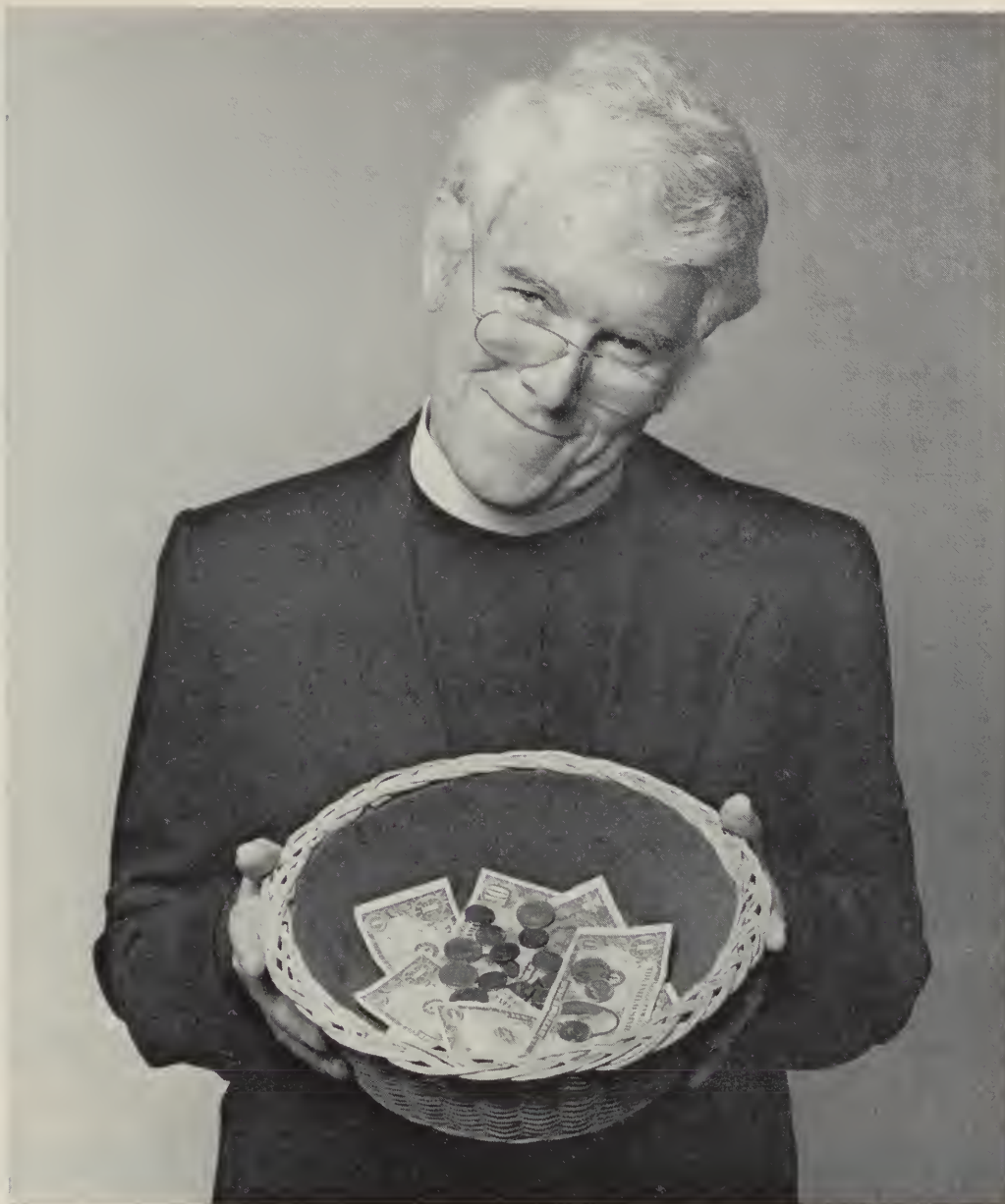
PRIMARY Physician participation in the State Early and Periodic Screen- CARE ing, Diagnosis and Treatment (EPSDT) Program is being expanded to the private sector by the Medicaid program. If any physi- PHYSICIANS cian is interested in participating, he should contact the Medicaid staff specialist assigned to this activity at (301) 383-2658. All physicians should have received the State Department of Health and Mental Hygiene bulletin on this subject dated June 19, 1979.

PHYSICIANS The Health Claims Arbitration Office is in need of physicians NEEDED in all specialties to serve on the arbitration panels. The vast majority of cases heard are against physicians. Where IMMEDIATELY no physician is available to serve as part of the panel, other health professionals are used.

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Executive Director

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Council

The Council met on June 21, 1979 and took the following actions:

1. Rejected a proposed resolution dealing with Medicaid patients that originated in the Liason Committee.
2. Authorized a public speaking training session sponsored by the Legislative Committee to train speakers appearing before General Assembly Legislative meetings.
3. Endorsed the concept of Hospice care for Maryland citizens, and also endorsed a Certificate of Need Application for a proposed hospice program to be offered jointly by the Baltimore City Health Department and the Deaton Medical Center.
4. Adopted a standing policy that the Auxiliary President and the Public Relations Committee Chairman be invited to Council sessions.
5. Endorsed in principle a proposed study of Primary Care Physicians in Baltimore but declined to participate financially in such study.
6. Approved an Executive Committee recommendation for purchase of a computer and related services (software and training package).

7. Adopted and referred to the Bylaws Committee the following recommendation of the Policy and Planning Committee, with instructions that bylaw amendments be prepared for submission to the 1979 House of Delegates Semiannual Session:

"The budget for a succeeding year should be developed each summer and presented to the Semiannual Meeting for its approval. The budget would be explained in detail and questions would be responded to by the Treasurer, a Budget Committee or other officers of the Faculty, at this meeting. Copies would have been mailed well in advance of the Semiannual Meeting to all Delegates, Alternate Delegates and Component Society officers. Should individual component societies wish to have a visit from a Faculty Officer or Budget Committee member, this should be encouraged.

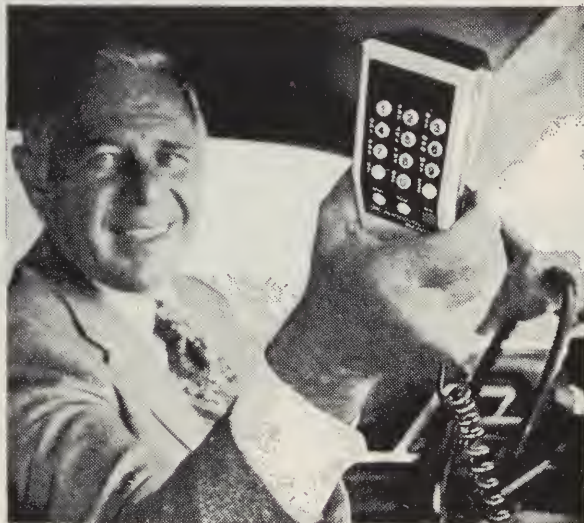
In addition, encouragement should be given to component societies to attend the budget setting meetings, which is current practice. This would enable Component Society officials to be aware of the detail and minutiae that goes into budget preparation and allow them to become fully-acquainted with the various items that make up the totals of line items.

Once the budget has been approved by the Semiannual Meeting of the House of Delegates, dues would be determined, rounding them to the next highest \$5 by dividing the number of active members into the

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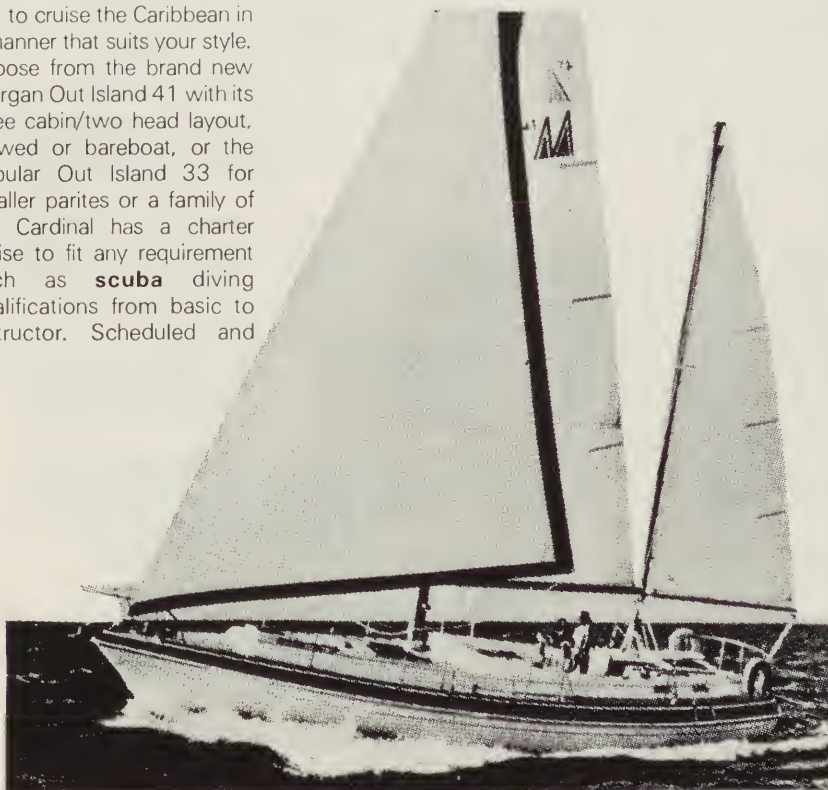
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total budget. Dues bills would then be prepared on this basis.

The Policy and Planning Committee feels this will accomplish meeting the needs of Faculty members, as Federal and other programs flourish and the necessity to respond to such Federal and State governmental actions becomes evident. This would also prevent any deficit budgets taking place on periodic occasions.

This change should be effected by the Bylaws Committee as promptly as possible so such bylaws can be approved at the 1979 Semiannual Meeting and actions taken for implementation of this proposal with the 1981 budget. It will obviously be too late to implement such a program for the 1980 budget, because of bylaw problems and constraints."

8. Adopted the following recommendations of the Policy and Planning Committee, after amending them, all of which read as follows:

RESOLVED, that social and scientific portions of the Semiannual Meetings be held inside Maryland at least every other year.

RESOLVED, that sites for Semiannual Meetings be selected a minimum of four years in advance of the meeting dates, such sites to be selected by the Program and Arrangements Committee and recommended to the Council, as provided for in the bylaws.

RESOLVED, that the Program and Arrangements Committee is authorized to determine the most appropriate manner of handling arrangements for scientific and social portions of the Semiannual Sessions held outside of the state and make appropriate proposals to the Council as required by the bylaws in this regard.

RESOLVED, that the Chairperson and one staff person be authorized to make site visits to appropriate locations after the site has been approved by the Council, and it is necessary to review the facilities for efficient and appropriate functioning of the scientific and social sessions.

9. Because the 1980 Semiannual Meeting dates conflict with the Jewish New Year, it was determined that an alternative date and site be selected and authorized the Executive Committee to approve such site selection and date.

10. Authorized providing administrative support for implementation of the Tel-Med System in Maryland.

Executive Committee

The Executive Committee met on June 21, 1979 and took the following actions:

1. Agreed to participate as Amicus in a suit filed by a physician against the Montgomery County Medical Society and physicians in Montgomery County.

2. Declined to join as Amicus in an appeal to the US Supreme Court involving the confidentiality of peer review proceedings. ☐

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THURSDAY, SEPT. 13

9-10 AM—UPDATE ON DIAGNOSTIC SKIN TESTING

William P. Coleman, Jr., MD, New Orleans

10-11 AM—HOW TO "ENCOURAGE" YOUR PATIENTS TO STOP SMOKING

Dabney M. Ewin, MD, New Orleans

11-12 NOON—UPDATE ON CORONARY BYPASS OPERATION

Charles W. Pearce, MD, New Orleans

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2-5 PM—SEMINAR ON INCREASING DIVORCE RATE AMONG PROFESSIONALS

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Gerald LaNasa, MD, New Orleans

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Uri P. Peles, MD, New Orleans

SATURDAY, SEPT. 15

Morning at leisure to explore this fascinating city on your own.

2-5 PM—SEMINAR ON PHYSICAL FITNESS

PHYSICAL FITNESS: DOES IT MAKE YOU LIVE LONGER, OR JUST LIVE BETTER?

John L. Overby, MD, New Orleans

NUTRITION—WHAT DO WE REALLY KNOW?

Alfredo Lopez, MD, New Orleans

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August, 1979 MD State Med. J. 25

Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL as cases become final.

IN THE MATTER OF LEWIS B. NEWBERG, MD, BEFORE THE COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Upon certain information coming to its attention, the Maryland Commission on Medical Discipline (the "Commission") determined to charge Lewis B. Newberg, MD, (the "Respondent") with violation of Maryland Code Anno. Article 43, Section 130 (h) (9), (14), (16) and (18).

(9) Willfully making and filing false reports or records, in his practice as a physician;

(14) Willful misrepresentation in treatments;

(16) Gross and willful and continued overcharging for professional services, including filing of false statements for collection of fees for which services are not rendered;

(18) Professional incompetency.

Appropriate notice of the charges and the grounds from which they arose was given to Respondent and a hearing on the charges was scheduled for July 25, 1978, at 9 AM. Prior to the time of the hearing, counsel for the Respondent, Marvin Ellin, Esq. and counsel for the Commission, Stephen J. Sfekas, Assistant Attorney General, engaged in extensive discovery. Depositions were taken of Mr. Robert Heird, Vice President of Blue Shield of Maryland; Paul Mullan, MD, Chairman of the Utilization Review Committee of Blue Shield; Cyrus Blanchard, MD, Chief of Otolaryngology at the University of Maryland Medical School; Stanley Blum, MD, Professor of Otolaryngology at the University of Maryland Medical School; Anthony Hammond, MD, President of the Maryland Society of Otolaryngology; Samuel Lumpkin, MD, Professor of Otolaryngology, Johns Hopkins University Medical School; Douglas Cody, MD, Chief of Otolaryngology, Mayo Clinic and David Austin, MD, Professor of Otolaryngology at the University of Chicago Medical School.

As a result of these depositions and other discussions, consultations, reports and findings, the Commission determined to enter into a Consent Order with the Respondent. The Respondent denies that he has violated any of the provisions of the Maryland Code Anno. Article 43, Section 130 (h) or that he is guilty of any improper, unethical or unprofessional conduct and believes that if tried he would be able to disprove the charges against him; however, he acknowledges the validity of this Order in an effort to avoid the expenses and unpleasantness resulting from these proceedings.

FINDINGS OF FACT

Although the Respondent does not agree that these findings are correct, the Commission finds that:

1. The Respondent's diagnosis of bronchitis and pneumonia in three children under the age of 12 without a physical examination and based solely on X-rays, is not an accepted medical practice.

2. The Respondent's method of treatment of three children under the age of 12 for bronchitis and pneumonia was not consistent with the methods of treatment accepted by medical practitioners competent to engage in this type of practice.

3. The Respondent's use of X-rays is excessive and often medically-inappropriate.

4. The Respondent, on one occasion, performed bilateral mastoid surgery on the same day, although the Commission believes that such bilateral surgery on the same day is contraindicated.

5. The Respondent performed a bilateral Caldwell Luc on Nov. 3, 1976, a left mastoidectomy on Nov. 7, 1976 and a right

mastoidectomy on Dec. 8, 1976, although the Commission believes that such surgery on one patient in so short a time span is contraindicated.

6. In addition to these specifics, other allegations concerning the Respondent's billing practice and indications for surgery were before the Commission.

7. The various depositions taken in this case demonstrate that there is considerable variance in the nomenclature used to describe various types of surgical procedures in the field of Otolaryngology. Thus, while the Otolaryngological Peer Review Committee, consisting of Drs. Blanchard, Blum, Lumpkin and Hammond believes that Respondent has engaged in the practice of "upgrading" of surgical procedures, Drs. Cody and Austin believe, based on the same materials reviewed by the Otolaryngological Peer Review Committee, that Respondent engaged in no improper billing practices.

8. Robert Heird, the Blue Shield representative, testified that Blue Shield had made no finding as to whether the Respondent was engaged in any improper procedure.

9. The Commission believes that in the circumstances of this case that it cannot find, as a matter of fact, that the Respondent engaged in any of the improper activities concerning false records, improper billing, or upgrading of procedures, with which he has been charged.

10. The Commission would also note that while the Otolaryngological Peer Review Committee had doubts as to the propriety of Respondent's practice, the Committee agreed that the Respondent was a technically-proficient surgeon. Drs. Cody and Austin concluded that the Respondent practiced well within the standards of practice of physicians practicing otolaryngology.

CONCLUSIONS OF LAW

The Commission adjudicates the Respondent not to be in violation of Section 130 (h) (9).

The Commission adjudicates the Respondent not to be in violation of Section 130 (h) (14).

The Commission adjudicates the Respondent not to be in violation of Section 130 (h) (16).

The Commission adjudicates the Respondent to be in violation of Section 130 (h) (18), but only to the extent specified in Findings of Fact numbers 1, 2, 3, 4 and 5.

ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 5th day of September, 1978, by the Commission JSA on Medical Discipline,

ORDERED that the Respondent be, and hereby is REPRI-MANDED and be it further

ORDERED that for a period of two years from the date of this Order the Respondent shall adhere to the following:

1. That Respondent shall cease to treat children under 12 years of age for bronchitis and pneumonia;

2. That Respondent shall permit the Commission or its agents to review the Respondent's patient records, billing records and X-rays, at reasonable times and in a reasonable manner;

3. That such inspections show Respondent to be practicing within acceptable medical and/or surgical standards;

4. That the Respondent shall practice surgery in conformity with the criteria set by the American Board of Otolaryngology; and be it further

ORDERED that should Respondent violate any of the foregoing Conditions, upon notification by and a hearing before the Commission, at which time the Respondent may be represented by counsel, and may present and cross-examine witnesses the Commission may reopen this proceeding and impose such additional sanctions or conditions as may seem appropriate; and be it further

ORDERED that two years from the date of this Order, if the Respondent shall have complied satisfactorily with the conditions of this Order, the said conditions will be lifted and will be of no further force or effect; and be it further

ORDERED that a copy of this Order shall be filed with the Maryland State Board of Medical Examiners.

The Commission would note that the Respondent has indicated his willingness to accept these conditions voluntarily, and the Respondent believes that a review of his records and practice will show him to be practicing in a competent manner.

JOHN E. ADAMS, MD, Chairman

CONSENT

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, and to call witnesses in my own behalf, and to all other substantive and procedural protection provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of this Order I may suffer the revocation or suspension of my license to practice medicine in Maryland.

I emphasize, however, that I deny any wrongdoing, any improper, or unethical, or unprofessional conduct in the past and deny that the findings of fact made hereinabove or conclusions of law are correct. I have agreed to the entry of this Order because I would conform to the conditions even if this Order were not filed, and because I desire the most expeditious resolution of this case.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

LEWIS B. NEWBERG, MD

AFFIDAVIT

STATE OF MARYLAND, CITY/COUNTY OF BALTIMORE:

I HEREBY CERTIFY, that on this 14th day of August, 1978, before me, the subscriber, personally appeared LEWIS B. NEWBERG, MD, and he acknowledged the foregoing Consent to be his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

ELLEN P. GARLICK
Notary Public

My commission expires: July, 1982 ☐
IN THE MATTER OF JOSEPH JACK, JR., MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE

FINDINGS OF FACT, CONCLUSIONS OF
LAW AND ORDER

Upon certain information coming to its attention pursuant to Article 43, Section 130 of the Annotated Code of Maryland, the Peer Review Committee of the Medical and Chirurgical Faculty of the State of Maryland initiated an investigation into the medical practice of the Respondent, Joseph Jack, Jr., MD. Thereafter, the Commission on Medical Discipline determined to charge the Respondent with certain violations of the Code. The violation charged involved the following subsection of Article 43, Section 130 (h) :

(18) Professional incompetence Appropriate notice of the charge and the grounds from which it arose was given to the Respondent and a hearing to consider said charge was scheduled before the Commission on March 15, 1977.

Prior to the date of that hearing, George L. Russell, Jr., Esq., the Respondent's attorney, contacted the Commission and advised that due to certain medical difficulties the Respondent would voluntarily withdraw from the practice of medicine until such time as the Commission heard and evaluated his case. Based on those representations, the hearing was cancelled and the case continued.

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Following the completion of certain surgical procedures and after a period of recuperation, the Respondent through his attorney asked the Commission to review his case, and determine if he is able to return to practice. The Commission again asked the Peer Review Committee to investigate this matter and make recommendations. By letter dated Jan. 23, 1978 the Commission received the Peer Review Committee's recommendation. On March 21, 1978 the Commission met with Dr. Jack and his attorney, which meeting resulted in the following Consent Order.

FINDINGS OF FACT

The Commission made the following Findings of Fact:

1. That the Respondent suffers from a recurrent meningioma in the sub-frontal region.
2. That neurosurgery was performed for this problem on or about Aug. 11, 1977.
3. That Jorge R. Ordonoz, MD, Respondent's neurosurgeon, stated that as of Nov. 28, 1977, "The neurological examination of Respondent is normal."
4. That John M. Hamilton, MD, is monitoring the Respondent's rehabilitative process and has recommended that the Respondent be permitted to return to the practice of medicine if he receives appropriate supervision.
5. That the Peer Review Committee has made certain recommendations regarding the Respondent's desire to return to practice by letter dated Jan. 23, 1978.

CONCLUSIONS OF LAW

Upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the Respondent, due to certain physical problems, was incapable of the competent practice of medicine.

ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 21st day of March, 1978, by the unanimous vote of the Commission on Medical Discipline,

ORDERED that the Respondent, an individual licensed to practice medicine in the State of Maryland, is hereby placed on PROBATION and be it further

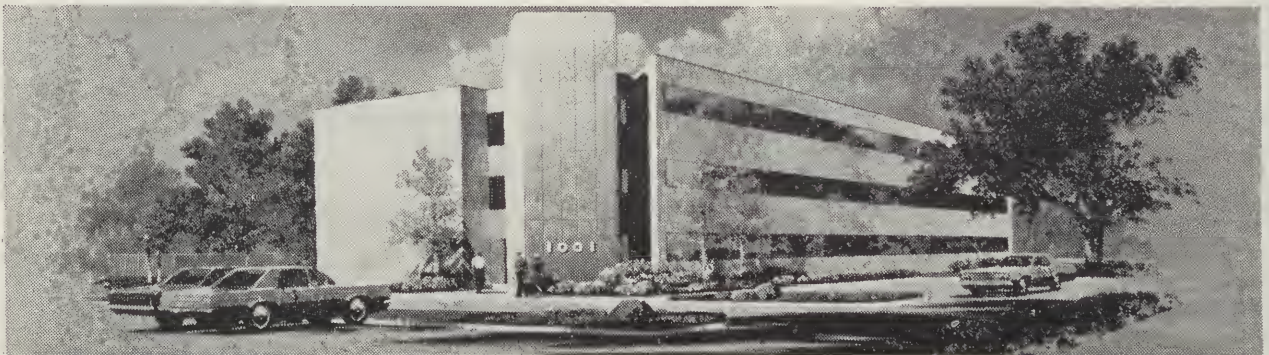
ORDERED that the Respondent's probationary status shall be based upon the following Conditions of Probation:

- (1) That the Respondent shall arrange for his psychiatrist to submit quarterly reports to the Commission. Respondent's continued probation shall be contingent upon such reports indicating that he is able to practice family medicine in a competent fashion.
- (2) That Respondent shall undertake and successfully complete a program in family medicine at the University of Maryland Medical School under the direction of Edward Kowaleski, MD, the content, length and frequency of attendance of that program subject to approval of the Commission.
- (3) That Respondent's practice of family medicine shall be monitored by the Harford County Medical Society. For one year of practice, such review shall be conducted at least once per month. Thereafter, the frequency of such review shall be as determined by the Harford County Medical Society.
- (4) That Respondent shall arrange for the Harford County Medical Society to submit quarterly reports to the Commission. Respondent's continued probation shall be contingent upon such reports indicating that he is practicing family medicine in a competent fashion.
- (5) That Respondent shall not admit patients to hospitals unless arrangements are made by Respondent for any patient so admitted to also be admitted to the service of another physician. Respondent shall arrange for the co-admitting physician or the chief of staff at any hospitals where patients are admitted, to submit reports quarterly to the Commission. Respondent's continued probation shall be contingent upon such reports indicating that he is practicing family medicine in the hospital setting in a competent fashion.
- (6) That Respondent shall not, during the six months' time period following the date of this Order, prescribe any Class II or Class III drugs. Following this time period, the Harford County Medical Society shall determine whether this restriction

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shall be lifted in whole or in part; and be it further,
ORDERED that should Respondent violate any of the foregoing Conditions of Probation, upon notification by and a hearing before the Commission, the Commission may revoke the Respondent's license to practice medicine upon any such showing; and be it further

ORDERED that two years after the date of this Order, the Commission will entertain a petition to terminate Respondent's probationary status. At that time, should the Commission determine that reinstatement would not be appropriate, the Commission may alternatively consider a request to modify one or more of the conditions of Respondent's probation and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners in accordance with Article 43, Section 130(m) of the Annotated Code of Maryland.

JOHN E. ADAMS, MD
Chairman, Commission on Medical Discipline

CONSENT

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, and to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation, I may suffer the revocation of my license to practice medicine in Maryland.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

JOSEPH JACK, JR., MD
STATE OF MARYLAND, CITY OF Baltimore to wit:

I HEREBY CERTIFY, that on this 12th day of April 1978, before me, the subscriber, personally appeared JOSEPH JACK, JR., MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

MAUREEN SPRIGGS
Notary Public

My commission expires: 7/1/78



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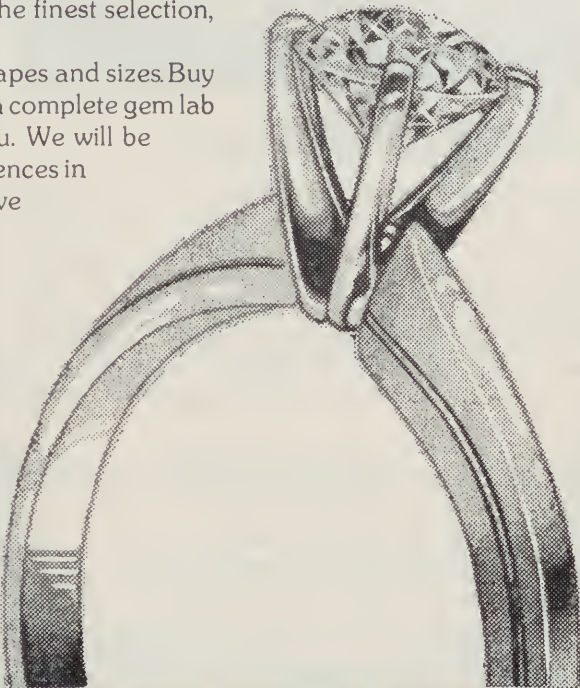
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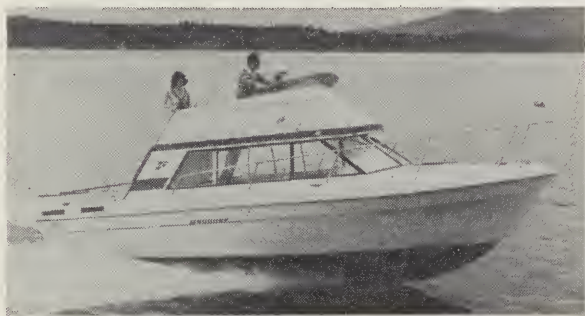
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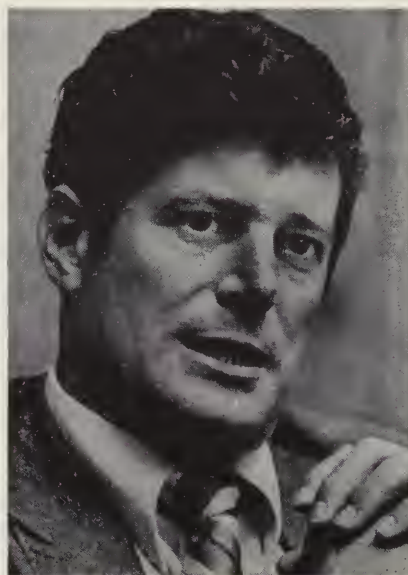
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Editor

Congressman Crane Speaks

Maintaining the independence and freedoms of medicine was strongly-endorsed by Congressman Daniel B. Crane (22nd Dist., IL) at the annual PAC luncheon. In a dynamic manner, he urged physicians to join together and resist governmental controls. This can only be accomplished by a commitment of effort from all, he said.

Physicians are the ones who know medicine best and how best to deliver health care. It is extremely important that the responsibility not be abdicated either to those who are less knowledgeable or those who wish to ensnarl health care deep within a bureaucratic morass, he felt.

Cong. Crane stressed that private medicine is an effective force. It must maintain its cohesion. Through unity its effectiveness will continue. There must be no surrender, he concluded. □



(Left)
**Congressman
Daniel B. Crane**

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Medical Miscellany

Annual Prize Award in Honor of Dr. Wendell Muncie

The Maryland Association of Private Practicing Psychiatrists and the Maryland Psychiatric Society jointly announce a contest for the awarding of a \$300 prize which will be made to the author who submits the best paper pertaining to a psychiatric subject.

The contest rules are:

Eligible to enter are physicians who reside or practice within the bounds of the Maryland District Branch of the American Psychiatric Association (i.e., all of the State of Maryland except Prince George's and Montgomery Counties) who, as of the deadline for submission of the paper, are no more than 10 years beyond graduation from medical school, have completed at least one year of an approved psychiatric residency and are currently active in the profession of psychiatry.

The subject matter is broadly any topic pertaining to psychiatry or allied fields, and may be of clinical, research, theoretical or other aspects of the subject. The paper must be unpublished, and there are no restrictions as to the length.

The prize will be awarded solely by discretion of the judges. The winner will be asked to read his/her paper personally at the joint meeting of the two societies scheduled for March 6, 1980.

All manuscripts must be received by Dec. 15, 1979. They should be mailed to: Douglas A. Puryear, MD, Committee Chairperson, The Wendell Muncie Annual Prize Award, 1204 Maryland Ave. Baltimore, MD 21201.

Hayfever Sufferers Sought for Allergy Study

Johns Hopkins allergists at Good Samaritan Hospital in Baltimore are seeking adults between the ages of 18-55 who suffer from ragweed hayfever, but have never had allergy shots, to participate in a trial of a new allergy therapy. The doctors hope that the treatment, a series of shots given once a week for five weeks, will suppress undesirable antibodies that cause allergy symptoms. Participants will receive free allergy tests and will be compensated for carfare and loss of time from work.

To volunteer for the study, call the Allergic Disease Center at (301) 323-2200, ext. 458, or write The Allergic Disease Center, Good Samaritan Hospital, 5601 Loch Raven Blvd., Balto., MD 21239. □

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By ELZA DAVIS

Ms. Davis, Faculty Communications Director, can be contacted for reprint and other data at 1211 Cathedral St., Balto., MD 21201.

You are an orthopedic surgeon; your name is Elliott Armstrong. On Saturday, Oct. 7, 1978, you are on duty in the Emergency Room of South Hirondeale Hospital in Montgomery County, MD. At around 2 PM, you meet Ms. Adelina Douglas. Ms. Douglas is complaining of pain and swelling of the foot. She was jogging two days ago, she tells you, when she tripped on a curb, fell and hit her left foot against a rock. There was considerable pain at the time of the fall, and Ms. Douglas, who works as a waitress, began soaking the foot in epsom salts and water. By this Saturday morning, the pain has not subsided and swelling has developed.

You send Ms. Douglas for an X-ray. When you see the films, you determine Ms. Douglas has sustained a fracture of the third metatarsal bone of the left foot. Accordingly, you place a cast on the foot, instruct Ms. Douglas in the care of the foot and the cast and ask her to make an appointment to see you in your office at the Forrest Office Building on Nov. 4th. You release Ms. Douglas at approximately 5:15 PM.

Adelina Douglas keeps her appointment on Nov. 4th. She tells you she has been in some pain throughout most of the month since the foot was set. You remove the cast and again X-ray the foot. A lump has formed on the anterior aspect of the left foot. Upon examination of the films and a visual examination of the foot, you inform Ms. Douglas that her foot is healing properly, and in time will be completely normal. You provide Ms. Douglas with an arch support to wear while working and ask her to return on Nov. 13th. She returns on Nov. 13th still complaining of pain. She has returned to work, but finds she is unable to move as quickly as necessary to keep up with the customers. You visually examine the foot and notice the lump has been reduced somewhat. You tell Adelina Douglas the lump and the pain will gradually reduce as the bone

continues to heal and that she will soon be back to normal. You then release Ms. Douglas from your care.

The next time you see Adelina Douglas is Monday, Aug. 6, 1979 at 9 AM. You and your attorney are seated around a table in the office of John Michael Gallagher, Chairman of an arbitration panel of the Health Claims Arbitration Office of the State of Maryland. The purpose of this meeting is to determine if you have been negligent in the treatment of Ms. Douglas, who is suing you for an amount in excess of \$5,000.

Your first indication of trouble was in the form of a summons, issued by the Health Claims Arbitration Office, and served upon you at your office by Deputy Sheriff Barney Victor on Feb. 20, 1979. Francis J. Prince, your attorney, responds by March 29th stating that neither you or South Hirondeale Hospital, also named in the suit, have been negligent in providing or rendering care and treatment to the claimant.

During the interval between the response of the attorney and the Aug. 6th panel hearing, the Health Claims Arbitration Office has been extremely busy. It is their responsibility to arrange for an arbitration panel to be convened in each instance of a claim against a health care provider in excess of \$5,000. The panel is composed of three persons—an attorney, a health care provider and a layman. Included in the health care provider group are: physicians, osteopaths, optometrists, chiropractors, nurses, dentists, podiatrists, physical therapists or hospitals and related institutions. In all cases, the attorney acts as panel Chairman.

In 1976, the General Assembly of Maryland enacted the Arbitration Statute. For the next two years, the law successfully withstood a series of court challenges. The first case was heard in the fall of 1978. This is how the procedure works:

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from each category. Of the remaining acceptable members, a panel is formed and the attorney, acting as chairman, contacts the attorneys involved and sets a pre-hearing conference. Requests for documents are submitted to the defendant's attorney as well as a list of interrogatories or questions the defendant must answer under oath. A further summons is issued, stating the date by which the aforementioned documents must be produced. After the pre-hearing conference has been concluded, the formal hearing on the action is convened.

The job of the arbitration panel is two-fold. First, it must determine if there is negligence. If the panel finds negligence, it then determines the amount of the award. The decision of the panel is admissible into court and presumed correct; that is, the disappointed party in the suit may ask for a court trial. Panel determination of negligence or lack thereof is presumed correct as is the amount of the award. The panel also must rule whether the fees for legal services are reasonable. The panel determines the assessment of costs for the arbitration proceedings, including the fees for services of the arbitrators. Presently, the attorney/chairman of the panel is paid \$60 per day and expenses. The other two members of the panel are paid \$40 per day and expenses.

These and other mysteries of Maryland's arbitration law were explained recently to a large audience of attorneys and physicians at two seminars presented by the Maryland Institute for Continuing Professional Education of Lawyers. Part of the presentation included a video tape of the case outlined above. Faculty members, plaintiff's and defendant's attorneys and members of the arbitration office played the roles of those involved in the case of Adelina Douglas vs. Elliott Armstrong, MD.

Since the panel is not bound by the technical rules of evidence, the proceeding is rather informal. The documents of evidence are passed around the table for examination by the arbitrators and attorneys. Questions follow some of the standard procedures you might hear in court; however, there are fewer objections, and the discussion is permitted to range far more than it is in court. To date, the Arbitration Office has received 185 cases. Six of these have been heard; 140 cases are in various stages of preparation; 12 have been scheduled for hearing. The case load is growing by approximately 20 cases per month. Nearly 3,000 volunteers have signed up to serve as panelists. Of this number, the largest group are the public members, with attorneys next, followed by health care providers.

Maryland's arbitration statute was developed in conjunction with the Faculty. The purpose of the law is to provide a mechanism for determining the merits of professional liability suits in a manner that is less costly and more expeditious for both plaintiff and defendant than the usual trial court procedure. Whether it will work as it was designed has yet to be shown. Many of the cases that will be decided by the panels will have to undergo court challenge so the parameters of the law can be defined. For the law to really work

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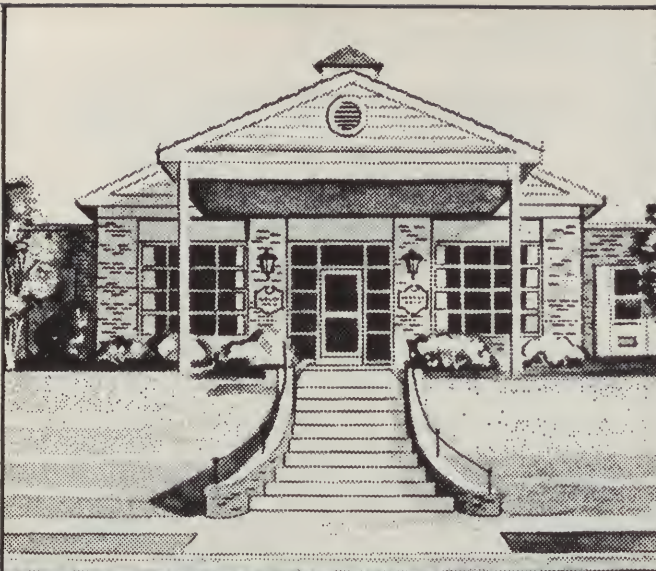
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will require the cooperation of all parties involved. An important aspect of the mechanism is the physician as a member of the arbitration panel. Currently, there are not nearly enough physicians serving, and most are asked to participate in panels dealing with matters outside their specialty areas. Since physician experts usually appear at the hearing procedure, it is not vital that the physician panelist practice in the area of medicine being considered. It is crucial, however, to have sufficient physicians from which to draw in any given area. Currently some counties are extremely deficient in the pool of physicians available for selection.

Physicians are urged to volunteer for a panel assignment, by contacting the Health Claims Arbitration Office, 201 W. Preston St., Baltimore, MD 21201, (301) 383-3910. Ms. Lynn Deutschman is the Assistant Director of the office and will be pleased to answer questions regarding the arbitration mechanism. In addition, information is available through the Faculty office.

PRN

By KENNARD YAFFE, MD

Dr. Yaffe, formerly Chairman of the Med-Chi Committee on Drugs, can be contacted for reprint and other data at 1211 Cathedral St., Balto., MD 21201, at the Faculty Building.

There exists much uncertainty about the proper use of PRN. Many questions have been received from pharmacists about "Refill, PRN." Frequently, doctors write for drugs used over an unlimited time, such as thyroid, digitalis, etc. in this fashion.

The question is raised as to the proper role of the pharmacist in filling such a prescription—should it be for one, two, five years?

In my opinion, the responsibility lies with the doctor to indicate some definite period of time. I think one year would be reasonable—it should create no significant hardship to do so, and would give some evidence to the pharmacist that the physician is retaining control of the patient's medication. I might also say that pharmacists are often reluctant to call the doctor by phone for this purpose because of the doctor's surly responses.


PRN is also too often used on prescriptions in directions for taking drugs. There are many drugs, such as classified and psychotropics, whose directions for use should be spelled-out precisely. For the average, mentally-alert patient, it is wiser and safe to do so. For the elderly and less alert, it is imperative to be absolutely explicit. Under some circumstances, failure to be explicit could even be considered negligence, a nasty word to physicians. □

SEMIANNUAL MEETING DATES

Sept. 12-16, 1979—Royal Sonesta Hotel—New Orleans, LA

Coming in the Journal:

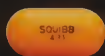
**A Sketch of the History of
Obstetrics and Gynecology in Maryland, 1770-1976,**
by John E. Savage, MD



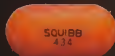
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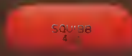
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See following page for brief summary

PRONESTYL® TABLETS

Procainamide Hydrochloride Tablets

The prolonged administration of procainamide often leads to the development of a positive anti-nuclear antibody (ANA) test with or without symptoms of lupus erythematosus-like syndrome. If a positive ANA titer develops, the benefit/risk ratio related to continued procainamide therapy should be assessed. This may necessitate considerations of alternative anti-arrhythmic therapy.

DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of overdosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been

reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Pronestyl Tablets (Procainamide Hydrochloride Tablets) providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride are available in bottles of 100 and Unimatic® single-dose packaging in cartons of 100. The 250 mg and 500 mg tablets are also available in bottles of 1000.



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Exclusive Profile/Interview of New Med-Chi President William A. Pillsbury, MD

By BLAINE TAYLOR

Contact Mr. Taylor, Journal Managing Editor, for reprint and other data c/o the Journal, 1211 Cathedral St., Baltimore, MD 21201

Introduction

"I used to be a 'Young Turk' and now I'm an old fossil," joked William Andrew Pillsbury, MD, Med-Chi's new President, during an unprecedented Presidential meeting with the Faculty's entire paid staff at its headquarters building at 1211 Cathedral St. in Baltimore on May 24, 1979. The extraordinary, face-to-face session, requested by Dr. Pillsbury, was intended to personally acquaint the 56-

year-old native Baltimorean with those on whom the Faculty depends for its daily functioning. (He found them, he says, "Innovative and dedicated.") Earlier—on Apr. 20th—the tall (6' 2"), affable and stocky General Practitioner had been interviewed by the **Journal** in his office at the Baltimore Gas and Electric Company's building at the corner of Lexington and Liberty Sts. in the city's core downtown, for which firm he has been Medical Director since 1974.

Born Aug. 29, 1922, Dr. Pillsbury graduated from Baltimore City College in 1940 and attended the University of Oregon before serving in World War II

as an infantryman in the Colmar Pocket battle in France and on the Siegfried Line in Germany as a member of the US Army's 63rd Infantry Division. By the time he was discharged as a Master Sergeant in 1946, Dr. Pillsbury had won the Bronze Star. He graduated from Loyola College two years afterward. The occupational physician and family practitioner graduated in 1952 from the University of Maryland School of Medicine. Following an Internship and General Practice Residency at Baltimore's Bon Secours Hospital during 1952-54, Dr. Pillsbury conducted a General Practice for two decades in Timonium, MD before assuming his current post as a full-time, salaried physician. During 1954-71, he was part-time Plant Physician for the Bendix Corporation's Joppa Rd. facility in Towson, MD; was President of the Baltimore County Medical Association, was Med-Chi Secretary for 12 years (and Council Vice Chairman and Chairman during 1975-78), as well as being a past member and Vice Chairman of the Baltimore County Board of Social Services.

A former Assistant Medical Examiner for Baltimore County, Dr. Pillsbury also served as physician for St. Paul's School during 1958-73, and for the period 1968-73, was staff physician for the Baltimore County Employees' Health Services, as well as being on the County's Youth Commission.

Since 1974, Dr. Pillsbury has been a member of the Medical Advisory Board of Philadelphia's Radiation Management Corp., Medical Consultant to the Edison Electric Institute's Industrial Health Committee, is President of the Maryland Occupational Medical Association and is a member of the American OMA and AMA, too.

At BG and E, Dr. Pillsbury supervises a staff of 15, including two full-time and one part-time physicians, four physicians' assistants and two nurses, plus clerical staff. The office runs satellite dispensaries at Timonium, at the Calvert Cliffs nuclear power plant and at its Madison St. complex in downtown Baltimore. Overall, the staff conducts pre-employment physical examinations, treats occupational and minor, on-the-job illnesses.

The name Pillsbury evolves from the older, English form of "Pilsborough," and the current MD, who hails from a family of physicians, proudly notes that his clan landed in the Massachusetts Bay Colony in the 1700s.

Dr. Pillsbury's own family consists of wife Vertalee McCusker (whom he married in 1946), son William T., 21, a student at Brandywine College; plus daughters Mrs. Vertalee P. Kozak, 32, a



DR. WILLIAM A. PILLSBURY, JR.
FACULTY PRESIDENT, 1979-80
(Photo by Udel and Solomon, Balto.)

John Deere Co. employee; Mrs. Laurel P. McCusker, 23 and Teresa R., 20, a student at Radford College. The senior Pillsburys also have a five-year-old grandson, Teddy.

We began our session by discussing Dr. Pillsbury's hopes for his Presidency.

Goals

As President, what do you hope to accomplish during your year in office and, realistically—with all the constraints you're under and with the amount of people with whom you have to deal—what do you think you CAN do?

The first thing is to try to continue what is being done and aggressively pursue it. Also, I'd like to try to get more of our full-time, salaried Medical Doctors to join Med-Chi as members. The fact that I'm in—as a full-time, salaried physician—shows that we, as a class, have gained acceptance, and I'm hoping that others will see the benefits of joining too.

Can ANY President come into office at Med-Chi and be an earth-shaker?

You can't be an earth-shaker because the President, as I see it, is committed to carry out the policies of the organization. Despite popular opinion, the President **isn't** a dictator, but can only exert leadership.

IS there a dictator at Med-Chi?

No, and I can cite you an example of what I mean. When I was President of the Baltimore County Medical Association, it was accused of being run by a clique. Our two biggest accusers were elected President in successive years—and we haven't heard a complaint out of them since! The reason is obvious: the people who're active in the Society and who devote the time to it are the ones who "run" it—if you want to use that word.



DR. and MRS. PILLSBURY
(Photo courtesy of Dr. Pillsbury.)

"I'm a firm believer in 'working through the system,' to use a phrase we used to hear a lot. If you want to change something, get in it.

At Med-Chi, everything is subject to the policy set down by the Council and the House of Delegates. Every Med-Chi President I've known has tried to get the younger physicians involved. The response has **not** been overwhelming whenever we've sent out cards asking for committee participation, either, from our members, particularly from those physicians with under five years of practice. Whenever we've had the name of someone interested in a particular Med-Chi committee, we've tried to appoint that person to that committee.

Several years ago, the Council Chairman was really the leader, but that's no longer true today. You'll find that the members of the House of Delegates—which is the ultimate policy-making body and source of authority—are people who're their own thinkers. It's more democratic now than its ever been in my view. The Council **can** only act in the interval between House meetings, but it can't do **anything** against policy set by the House. I like to think that it's a fairly smooth and fast-working process of getting things done. Most of the House members aren't previously-instructed, and so can think and react for themselves as things come up on the floor of the House during discussions.

Committee Importance

I think too much importance is placed on the Council and Executive Committee. Basically, the real gut-work of the Faculty is done by the Committees. They're our unsung heroes. Many of them come from great distances and work like hell! They serve and produce excellent reports. You can't rank the Committees in order of their importance, because they all have different functions—Peer Review, for example, and Preventive Health and on and on.

What do you think have been some of the more important items that've come out of the Med-Chi system that've later been enacted into law or otherwise affected the public's health?

One of the most important advances in recent years has been the work of Jack Sargeant and Dr. John Dennis in setting up the Commission on Medical Discipline, Drs. Joseph Berman and Katie Borkovich with their Peer Review Committee and, just last year, Dr. Jerome Collier with the Physician Rehabilitation Committee. Then, there are the real Faculty workhorses: Drs. Russell Fisher and Charles O'Donnell, the late Mac Boyer, the late Albert Goldstein (the current Treasurer's father), Arthur Keefe and Karl Mech, Sr., to mention a few.

The AMA Presidency

Is it the goal of every Med-Chi President to perhaps become AMA President someday?

Looking back over the Med-Chi Presidents I've known, I'd say about 50% of them were interested in being active on the national level, but not necessarily the AMA Presidency. I think we're blessed with our Med-Chi Delegates to the AMA (ed. Note: see **Journal**, April, 1979). Our representatives—Russell Fisher, Charles and Steve Padussis—are all excellent and work hard.

Occupational Physicians

Are there many occupational physicians such as yourself in Maryland?

No, unfortunately, because not many industries have full-time physicians. Some of those who do are the Chesapeake and Potomac Telephone Co. (ed. note: see **Journal**, August, 1977, for a profile of John R. Davis, MD, of the C and P), Western Electric; also Bethlehem Steel Corp. I'm President also of the Maryland Occupational Medical Society, which is a statewide group having about 60-70 members. Many of them are part-time or run clinics to handle occupational cases. Nationally, there're about 4,000 occupational physicians.

So, in Maryland, there're about 65 doctors out of a total physician population of about 6,000. That's a rather miniscule percentage, but I imagine it's growing.

Yes, because of the carcinogen regulations and various programs of government-mandated medical surveillance concerning asbestos, for example, and radiation, as seen recently in the Three-Mile Island incident involving the Federal Nuclear Regulatory Commission.

Considering the Three-Mile Island affair, if anything similar happened at the Baltimore Gas and Electric Co.'s Calvert Cliffs facility, would you be the one to go down there to take charge medically?

Yes. I would be down there—responsible for the biological effects—the minor things—not the health physics side of it, though.

Is there a tendency throughout business and industry—which is now getting bigger and bigger—to employ their own, in-house physicians to treat their employees?

Yes. The basic reason—despite popular misconception—is **not** to provide a source of information to management. Confidentiality of patient records is the **rule**, **not** the exception. We're very serious about that, but a lot of people think that the company doctor is a stoolpigeon.

The shortage of primary care physicians in certain areas has forced some companies to offer in-house treatment of much illness.

The old image of the company physician was of someone who could give out aspirin and who was strictly on management's side. In recent years, occupational medicine has become a specialty. It requires not just a knowledge of medicine, but entails also a grasp of toxicology and epidemiology. In the chemical industry, for instance, they're finding more and more toxic substances, such as

kepone. Med-Chi has an Occupational Health Committee that deals with these kinds of problems, too.

Image Concerns

As a physician what—in your mind—is the biggest threat to medicine today? What are you, personally, most concerned about?

Public image. Certain people in the country are determined to make doctors the scapegoats for inflation. I'm talking about liberal politicians like Ted Kennedy. To give you an example, there was a quote from someone that they weren't going to give doctors a special allocation of gasoline, if it came to rationing, because they didn't want them riding around in their yachts and Cadillacs. I think there's a basic resentment of physicians among some segments of the community, yet everyone seems to like his or her own doctor. We should take steps to improve our own image. It can be done if the art of medicine were taught as well as its science. I'm a firm believer in communication, and I think that if doctors would share their decisions with their patients—the why of things—that their image would improve somewhat thereby. I'm not talking about why you're removing a breast, but why you're prescribing a certain medicine and what the side-effects of it will be.

Do you think that this'll make the doctor more human to the patient?

Of course! I think doctors today are much more science-oriented than was my generation. After you've taken out 2,000 appendices, you don't get too excited about another one—but it's a big problem to the person concerned!

Hobbies

What are your hobbies?

My wife will tell you that I'm a very passive, intellectual individual. My hobby is relaxing! I'm an opera buff, and I go whenever I can—rather infrequently—to the Metropolitan Opera House in New York. I'm into a hobby called latch-hooking, which is sort of like the old rug-weaving, but using wool and acrylics instead to make pillow covers and wall-hangings. It's very archaic, but relaxing, because I find I can do it and listen to music at the same time.

I like to read history, especially that of the American Civil War, which brings me to the subject of the Med-Chi Library and its Librarian, Joseph Jensen. The Library is one of the things that thrills me about Med-Chi, because we probably have one of the richest library traditions of any medical society in the country. I think that in the person of Mr. Jensen, we have an excellent Librarian—a person not just interested in books—but also in the people who use them. I'm just delighted to see the Library's business picking up.

Future

What about your future? Do you plan



A PILLSBURY FAMILY BIRTHDAY CELEBRATION, JANUARY, 1979: (from left to right) daughter Vertalee, Dr. Pillsbury, Mrs. Pillsbury, grandson Teddy, son William (in glasses, standing) and daughters Teresa and Laurel.

to stay here as a physician until your retirement, whenever that is?

Yes. At present, I have every intention of knocking off at age 65. I'm a firm believer in youth. We need younger blood and innovation, which is one of the reasons why I'd love to see younger physicians getting active in the Faculty. I'm looking forward to traveling in Europe during my retirement. Don't get me started on Europe and the Renaissance!

All right, I won't! Thank you, Dr. Pillsbury.

Acknowledgments

The author thanks Med-Chi Communications Director Elza Davis for assistance and Mrs. Mildred Chronister for secretarial services. □



JOVIAL INCOMING AND OUTGOING FACULTY PRESIDENTS WILLIAM A. PILLSBURY, MD (left) and FRANCIS C. MAYLE, JR., MD (right) with Dr. Mayle's Past President Medallion.
(Photo by Tadder, Balto.)

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INDICATIONS: Therapeutically, (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. Prophylactically, the

ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



ANNUAL REPORTS TO THE HOUSE OF DELEGATES OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

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OCTOBER 10-12, 1979

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PROGRAM

NEURO CT

October 10, morning

Welcome—John M. Dennis, M.D., and Joseph Whitley, M.D.

Moderator: Nancy Whitley, M.D.

CT of the Larynx — Stephen Cisternino, M.D.

CT of the Pulmonary Nodule — Stanley Siegelman, M.D.

CT of the Mediastinum and Pleura — Charles Putman, M.D.

CT Scanning of the Pancreas — Ralph Alfidi, M.D.

CT Scanning of Kidneys and Adrenals — Stanley Siegelman, M.D.

Comparative Aspects of Ultrasound and CT of the Retroperitoneum — Conrade C. Jaffe, M.D.

October 10, afternoon

Moderator: Morgan Dunne, M.D.

CT of the Pelvis — Nancy Whitley, M.D.

CT in Musculoskeletal Neoplasms — Peter Mueller, M.D.

Sequential CT Scanning after IV Contrast — Ralph Alfidi, M.D.

Clinical Application of Multiplanar Reconstruction in CT of the Abdomen — Conrade C. Jaffe, M.D.

Interventional CT — Peter Mueller, M.D.

October 11, morning

Moderator: Stephen Cisternino, M.D.

Global Abdominal Anatomy by Ultrasound and Computed Tomography — Morgan Dunne, M.D.

Computed Tomography of Trauma — Edward Druy, M.D.

New Developments in CT Technology — John Perry

The Use of CT in Radiation Therapy Planning — Ralph Scott, M.D.

October 11, midday: Workshop sessions at the University of Maryland Hospital and Johns Hopkins Hospital will demonstrate CT diagnostic activities in clinical settings.

Location: INTERNATIONAL HOTEL, Baltimore-Washington International Airport.

Pre-registration: Early pre-registration by mail is encouraged since conference facilities necessitate limited enrollment. Registration, with a \$15 late fee, will be possible on a space available basis at the International Hotel, 7:30 am, October 10 and 10:00 am, October 11.

Fee:

	Physicians	Residents, Interns and Other Professionals
Full 3-day course:	\$200	\$135
Body CT session only:	\$125	\$ 80
Neuro CT session only:	\$125	\$ 80

The total registration fee, payable in advance, includes the cost of instructional materials, coffee breaks, lunches, and reception.

Credits: 20 credit hours in Category I of the Physician's Recognition Award, American Medical Association, for the entire course.

Supported by an educational grant from Pfizer Medical Systems, Inc.

October 11, afternoon

Moderator: Krishna C.V.G. Rao, M.D.

Functional CT Anatomy — Mokhtar H. Gado, M.D.

Sensitivity and Specificity of CT Scanning in Intracranial Neoplasm — Sadek K. Hilal, M.D., Ph.D.

CT in Sellar and Parasellar Lesions — Fred J. Hodges, III, M.D.

Normal and Abnormal CT Anatomy of Intracellar Structures — Sadek K. Hilal, M.D., Ph.D.

October 12, morning

Moderator: Richard F. Mayer, M.D.

CT in Stroke — Irvin Kricheff, M.D.

Intracranial Anomalies — Derek C. Harwood-Nash, M.D.

CT in Certain Pediatric Conditions — Krishna C.V.G. Rao, M.D.

Moderator: Harvey H. Levine, M.D.

CT in Head Trauma — Pulla R.S. Kishore, M.D.

CT in Degenerative Brain Disease — Giovanni DiChiro, M.D.

CT in Infection — S.H. Lee, M.D.

October 12, afternoon

Moderator: Thomas B. Ducker, M.D.

Computed Tomography/Metrizamide in Evaluation of Pediatric Spine — Derek C. Harwood-Nash, M.D.

CT/Metrizamide in the Adult Spine — Mokhtar Gado, M.D.

Use of Metrizamide and Alternative Methods of Evaluating Posterior Fossa Lesions — Irvin Kricheff, M.D.

Recent Trends in Neuro-imaging Modalities — Giovanni DiChiro, M.D.

Moderator: Giovanni DiChiro, M.D.

Panel Discussion

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How The Medical and Chirurgical Faculty Operates

By ELZA DAVIS

Ms. Davis is Med-Chi's energetic Communications Director.

Med-Chi, the Medical and Chirurgical Faculty of the State of Maryland, has virtually grown up with America, since its incorporation in 1799. As Maryland's society of medical doctors, Med-Chi ranks as one of the oldest—and one of the most progressive—organized medical associations in the United States.

Since Med-Chi's incorporation by a Special Act of the Maryland Legislature, the Faculty has worked to continue its founding tradition: "... To secure ... just laws relating to the practice of medicine and public health."

The Faculty includes in its membership more than 5,000 physicians in Maryland. Many members do important work on the Faculty's network of 45 active committees engaged in a wide range of interests and activities.

Med-Chi is composed of 24 component medical societies, one for each Maryland County and one for Baltimore City. The Faculty, in turn, a component of the American Medical Association, is a non-profit organization and is tax-exempt.

Officers of the Faculty, elected by the House of Delegates at each Annual Meeting, consist of the President, President-Elect, First, Second and Third Vice Presidents, Secretary and Treasurer.

Voting members of the House of Delegates consist of the members of the Council, a member of the Board of Medical Examiners, one delegate from each component society, plus one additional delegate for each 50 active and 40-year members or major fraction of each component. The House of Delegates meets twice each year, at the Annual and the Semiannual meetings.

Between meetings of the House of Delegates, author-

ity to conduct the business of the Faculty is vested in the Council. Councilors are elected by the component societies in the ratio of one councilor for each 200 active and 40-year members or portion thereof. Council voting is proportional, based on the total membership of each component society. The Council elects its own Chairman and Vice Chairman. These two, plus the Immediate Past President, President, President-Elect, Secretary and Treasurer of the Faculty, constitute the Executive Committee. This committee acts in an advisory capacity to the officers and staff in questions of immediate importance between meetings of the Council, and is directly responsible to the Council.

Daily operations of the Faculty are vested in the Executive Director and staff, who are responsible to the Council, officers and committee chairmen. Chairmen of Faculty committees are appointed annually by the President. A staff member is assigned to each committee, and works under the supervision of the committee.

Self-regulation is a term often misunderstood today, but it is critically-important to today's physician. Med-Chi has developed an efficient program of self-regulation. Through its Peer Review, Physician/Patient Relations and Drug Committees, Med-Chi maintains one of the most effective systems of monitoring physicians' practices in this country.

The Faculty requires no political or institutional intervention to ensure members' competence. Instead, member physicians act as checks and balances, working closely with committees on the component society level and with the State Commission on Medical Discipline.

□

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BEFORE HAIR FOREVER

AFTER HAIR FOREVER

Speech of Francis C. Mayle, Jr., MD to the Med-Chi House of Delegates, May 2, 1979, Hunt Valley Inn

Dr. Cloud, Delegates, members of the Faculty, their families and guests:

In looking back over the original Articles of Incorporation of the Faculty, one of the duties of President is to give a yearly summation of the term of office and, to paraphrase a topical term: "This has been a year of good news and a year of bad news."

It has actually been the year of awards and the year of conflict. This year we were very fortunate to have two of our members honored for their public speaking achievements at the AMA National Leadership Conference. Dr. Raymond J. Donovan, Chairman of our Public Relations Committee, received First Prize for a television talk show. Dr. J. Roy Guyther, a member of our Council, won Second Prize for speaking before a professional audience. Both of these awards consisted of a cash prize presented to the Faculty and a plaque commemorating this event given to the award winners.

The Faculty itself won an award for its renovation of one of the buildings acquired last year, located next to the Faculty headquarters. This award was given by the Baltimore Heritage for preservation and restoration of the historical property located on Maryland Avenue, but, I think even more importantly, each member of the Faculty should receive an award for responding to the needs of the community in providing higher quality medical care and service to the public, especially Committee Chairmen and members should be congratulated for their hard work in carrying out the various responsibilities entrusted to them in the Faculty Bylaws. Though many of these activities seem mundane and routine, many are very important, requiring much time and effort—and contribute in great part to the image of the profession. I have chosen to tell you about a few of the Committees to illustrate my point.

Our newly-formed Physician Rehabilitation Committee now has over 60 cases under its jurisdiction. This group should

be commended for offering a helping hand to their colleagues and families.

Our Peer Review group has come a long way since its inception under Dr. Russell Fisher when he was Faculty President. It is now referring many cases to the local level and has begun to turn its attention to areas involving the quality of inpatient care at institutions throughout the state. Also, in connection with this, our Drug Committee finds a never-ending problem with physicians who are not firm enough with their patients in fulfilling requests for Schedule II substances. Our cooperation with drug authorities and law enforcement officials continues to be at a high level.

Government agencies, however, have proliferated, and control of physicians and their practices continues. We are fortunate in adding to our staff an expert in health planning and, thus, are able to monitor more effectively the activities of both state and local planning agencies. In this way, we are better able to *ACT* rather than *REACT*. I am glad to say we have been able to provide more input and influence over some of the decisions in this area.

The Health Services Cost Review Commission is still with us. We are attempting to work with this group in areas of mutual concern, and are reviewing with them the necessity for some ancillary services. Our Ad Hoc Committee headed by Dr. Harry F. Klinefelter anticipated public announcements some months ago by national Blue Cross and Blue Shield about inappropriate testing of in-hospital patients. Our work in this area continues. We must, and will, continue to monitor these areas as this presents an avenue for reduction of health costs—one which could effectively produce cost-saving for our patients.

Our Committee on Continuing Medical Education has had some difficulties this year where an attempt has been made on a national level to interject bureaucracy and removal from local jurisdiction the authority for accrediting CME

programs. Hopefully, this has been resolved and the Council has given its full backing to this Committee in attempting to correct the matter.

Our Liaison Committee with the State Department of Health and Mental Hygiene, has worked consistently in attempting to improve reimbursement and procedural matters in the Medicaid Program; unfortunately, this group has been unsuccessful in resolving all the issues, but remains undaunted in its continuing efforts in this direction. Let us hope some progress can be made this year.

Our Legislative Committee reviewed over 400 items of legislation during the 90-day legislative session. We were partially successful in moderating some of the legislative proposals; unsuccessful in defeating some legislation and successful in others. Overall we can consider this to be as good a legislative session as we have had, although not perfect. Dedication on the part of individual physicians and staff is responsible for our record.

Our Policy and Planning Committee has become more active than in past years and is currently studying many areas where improvement in our member benefits hopefully can take place, and how to adjust our dues picture so we are not faced with periodic operating deficits because of inflation and the cost of doing Faculty business. This House of Delegates will have the opportunity of reviewing several proposals, probably at the next Semiannual Meeting.

The Public Relations Committee has been very active presenting radio, television and public talk shows. It is currently taking leadership in promoting the Tel-Med program on a statewide basis. Full details have not been completed as yet. This, again, speaks of the good the physicians in Maryland are performing for the benefit of the public—their patients.

These, then, are some of the highlights of the past year. The origins of many of these programs came before my term of office and, needless to say, the seeds of

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other programs which will come to fruition in the next several years may have been planted. We will not know until the time comes and we see what evolves. I think we can all be proud of a group of dedicated physicians who give so much of their time in reaching these accomplishments.

We have also seen a tremendous growth in our Medical Library use, and many of the other services given by the staff of Med-Chi. This loyal group of *DEDICATED EMPLOYEES* certainly deserves our heartfelt thanks and gratitude because, believe me, without them—I have learned this year—we could not exist. Unselfishly in many, many ways, they have given of themselves for our good and for the good of our patients.

But enough of what has happened this year. In preparing this speech I had the opportunity to go over some data, aided by our Librarian, who did much of the research about how this Faculty came to be, what it is today and why we are here today. I think it is rather fascinating to go through some of these highlights.

Initially, the Faculty was established by an Act of the Maryland Legislature in 1798. It is interesting to note the purpose of the organization, which is: "To promote and disseminate medical and surgical knowledge throughout the state and to prevent citizens thereof from risking their lives in the hands of ignorant practitioners or pretenders to the healing art."

This Charter, as granted by the Maryland Legislature, provided the means of carrying out these charges. The Charter states that the Faculty is to elect a Board of Medical Examiners who will provide for the licensure of physicians. The Faculty is permitted to charge for the licenses and also empowered to investigate and fine those practicing without licenses. The income from the licenses and fines was to accrue to the Faculty. Regarding the charge to promote and disseminate medical and surgical knowledge throughout the state, the Faculty was given the power to act as it judged to be conducive to carrying out that charge. Interestingly, the members of the Faculty and their successors were declared to be one community, corporation and body politic forever by, and under the name of, the Medical and Chirurgical Faculty of the State of Maryland. These words are very important, as I will try to point out.

The First Annual Business Meeting was held in June, 1799. The main business at that time was election of officers and election of the Board of Medical Examiners. Constitution and bylaws were drafted and adopted. This meeting, incidentally, was held at the State House in Annapolis. In 1807, the College of Medicine of Maryland was founded, which eventually became the University of Maryland Medical School. This event occurred primarily because of the efforts of the Medical and Chirurgical Faculty. The Charter establishing the Medical School names the Medical and Chirurgical

Faculty membership as patrons and visitors of the college. The President of the Medical and Chirurgical Faculty was the Chancellor of the College. The members of the Board of Medical Examiners, elected by the Faculty, were trustees of the Medical College. The members of the Board of Medical Examiners, together with the President and professors, were charged to be "One community, corporation and body politic to have continuance forever by the name of the Regents of the College of Medicine of Maryland."

In the same year, the State was divided into seven districts. A district society was set up within each area. These were to be components of the Medical and Chirurgical Faculty. Things remained in that manner until 1839, when individual county medical societies throughout the

state were formed as components of the Medical and Chirurgical Faculty.

More importantly, about 1830, at the Annual Meeting of the Faculty, it was determined that everything possible had been done to prevent citizens from risking their lives at the hands of ignorant practitioners or pretenders to the healing art. Accordingly, it was decided to turn attention toward promoting and disseminating medical and surgical knowledge throughout the state. As a result of this charge in the Faculty Charter, a resolution was passed establishing a Library and a committee of five, to be called the Library Committee, appointed to purchase such periodicals and other standard works in medicine as it deemed proper to be placed in some suitable situation for the use of the members. The



DR. MAYLE (center) listens to Annual Meeting proceedings at Hunt Valley Inn. Others (from left to right) are: Mrs. Ian (He'en) Anderson; Mrs. Bernadette Lane, Baltimore City Medical Society Executive Director; Mrs. Barbara Mayle and Ms. Constance L. Norris, BCMS Assistant Executive Director.



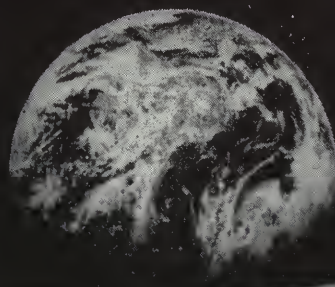
CHARLES BUCK, PhD, Secretary of the State Department of Health and Mental Hygiene, addresses the Med-Chi House of Delegates during the Annual Meeting at Hunt Valley Inn, May, 1979. Seated (left to right) are Parliamentarian Dr. William Evans and Faculty President Francis C. Mayle, Jr., MD.

(Photographs by Faculty Librarian Joseph E. Jensen.)

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Library first opened its doors on July 1, 1839 in the office of Dr. John Fonerdon, the first Librarian.

Also in 1839, the *Maryland Medical and Surgical Journal and Official Organ of the Army and Navy of the United States* began publication. Aside from occasional annual transactions, this was the Faculty's first attempt at a regular *Journal*.

In the same year, the Faculty passed a resolution recommending that delegates from all states meet together to form a National Medical Society. The Faculty appointed three delegates to assist in the formation of such a National Society and to represent the Faculty at the first meeting. This effort, initiated by the Faculty, was the beginning of the drive that led to the formation of the American Medical Association and its first annual convention, held in Baltimore in 1848 at the invitation of the Faculty; 1839 was a busy year. In that year, an Act of the Legislature authorized Thomasonian and Botanic physicians to charge and receive compensation for their services and medicines without being licensed. The effect of this Act was to revoke the 1798 Charter of the Faculty, because the Act stated: "It may and shall be lawful for each and every person in this state to charge and receive compensation for their services and medicine in the same manner as physicians are permitted to do." As a result of this Act, physicians ceased joining the Faculty and ceased applying for license, cutting off the Faculty's only source of income. It was not until almost 50 years later, in 1886, that, under the Presidency of Dr. John Quinan, that the Faculty was able to successfully establish the priority of its charter over the 1839 Act, based upon the important legal concept of *inviolate chartered rights*.

Some interesting high points: In 1857, the first Faculty Hall was established at 47 North Calvert St. Incidentally, a Museum and Library were with us at that time. The whole building cost \$3,425. In 1874, a State Board of Health was established as a result of lobbying by the Faculty. In 1881, a Library Building Committee was established, and this eventually led to our present Faculty Building on Cathedral St.

In 1882, the first black physician applied for membership in the Faculty and was unanimously elected. This was Dr. Whitfield Windsey, a graduate of Harvard University. That same year, two other black physicians were admitted. To show how up-to-date we were even then—in 1885, the Faculty's Constitution was amended so the words: "gentlemen" or "gentleman" were changed to "persons" and "person" allowing for admission of female physicians to the Faculty. ERA was here first!

In 1891, again, problems seemed to rise. After several years of effort by the Faculty to establish the State Board of Medical Examiners, a new law confirmed the Faculty's Charter of 1798, in that the Board was to be elected by the Faculty. The Board was financed by the Faculty

and the monies collected by the Board belonged to the Faculty. The State Board was actually organized in June, 1892 at an Annual Meeting of the Faculty which elected the first members of the Board. This 1891 law was a compromise on the part of the Faculty, in that a second Board of Examiners was to be elected by the State Homeopathic Society and was to have the power to license homeopathic physicians. It is only in recent times that the State Board of Homeopathic Examiners ceased to function.

In 1894, the 1891 Act was amended to require all practicing physicians to register at their county court house. The purpose of this was to give the Faculty a way of determining whether or not a practicing physician was licensed. All physicians practicing in Maryland on or before June 1, 1892 were automatically licensed. The Board of Medical Examiners continued to function for many years with its members unpaid, and the Faculty bearing the cost of operating the Board and prosecuting those who continued to practice or set up practice in violation of the Medical Licensure Act.

In 1896, the Frick Fund was set up; Also, Marcia Noyes was hired as the Faculty's first resident Librarian. She later assumed the duties of Executive Secretary as well, and served the Faculty until her death in 1946. In 1898, the Constitution of the Faculty was modified so that the Secretary of the Faculty became a salaried officer, beginning the move toward a supporting staff, upon which we depend now. In 1899, the Centennial of the Medical and Chirurgical Faculty brought a major membership drive. Through this drive, county societies were established in every county and close to 100% of the practicing physicians in Maryland became members.

Some other highlights show the Faculty Headquarters were dedicated in 1909. In 1946, Miss Noyes died, and her funeral was held in Osler Hall. She is the only individual who has been so honored.

Thus, in summary, I have given, I hope, a thumbnail sketch of what I consider to be the salient highlights of the Society. I think it is important that we realize in a day like today, that we are a unique group of individuals which have a power within the state to perform many of the duties which we have given over to the State. These duties are ones which, in essence, would help us to better fulfill our original Charter in combating the inroads of socialization, economic controls, and other insidious ideas and which, in non-medical hands, could lead to the complete subrogation of our time-honored profession.

Ladies and gentlemen, we have been given a Charter which, I understand, exists in perpetuity, cannot be revoked, that gives us the strength and the power to act. It also charges us with a very important duty—that we "promote and disseminate medical and chirurgical knowledge throughout the state and prevent citizens from risking their lives in the hands of ignorant practitioners or pre-

tenders to the healing art." Ladies and gentlemen, in this day of advocacy, we have many, many pretenders, and I think it is very important that we realize the most important sign or signs we see in our patients are those of their mental and physical illnesses, *NOT* those of the sociologists, economists and others who would tell us how to do what we know best to do. Thank you. □



DR. WELTY RECEIVES A. H. ROBINS AWARD: Louis S. Welty, MD of Easton has received the A. H. Robins Award for distinguished community service rendered by a physician above and beyond the call of duty. The Award was presented at the Med-Chi Presidential Banquet of the 181st Annual Meeting at Hunt Valley Inn.

In nominating Dr. Welty for the Award, Talbot County Medical Society President, Dr. Richard Stephenson, said: "Dr. Welty is an outstanding physician as well as an outstanding individual, and I personally cannot think of anyone who is more deserving of this recognition and Award." Dr. Welty is a graduate of Amherst College and received his Medical Degree and public health degree from Johns Hopkins University. He has served as County Health Officer for both Caroline and Talbot Counties. In that capacity, he was active in organizing the National Association of County Health Officials and the Maryland Conference of Local Health Officers. He was the first health officer in Maryland to use the Salk Polio vaccine to control an outbreak of Poliomyelitis. While President of the Easton Rotary Club in 1944, he brought to the County the first speaker at a public gathering to promote and explain the philosophy of Alcoholics Anonymous. From this beginning, there is now an alcoholic clinic in Easton and between 10-12 meetings per week in the county. Dr. Welty was instrumental in the establishment of two very active groups for children in need of assistance. The first, Bethany House, Inc., a network of group homes for potential juvenile offenders in the County, receives court-assigned children for rehabilitation. Youth, Inc. is a group of concerned citizens who organize seminars, a coffee house and recreational activities for high school youth. In the photo (by Tadder of Baltimore), Dr. Welty (right) receives the Award from Robins representative Dieter Scherer (left), while Faculty President Dr. Francis C. Mayle, Jr. (center) beams approval.

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MINUTES
First Meeting
181st Annual Session
House of Delegates
(296th Meeting)
Medical and Chirurgical
Faculty of the State
of Maryland
May 2, 1979

Hunt Valley Inn, Hunt Valley, MD

The 296th meeting of the 181st Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was called to order at 9:40 AM, Wed., May 2, 1979, at the Hunt Valley Inn, Hunt Valley, MD, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterick indicates an alternate delegate:

Doctors
Allegany County

Leslie R. Miles, Jr.

Anne Arundel County

Leo A. Courtney
 Charles R. MacDonald
 David S. McHold

Baltimore City

Ian R. Anderson
 Franklin L. Angell
 *Raymond M. Atkins
 Shahid Aziz
 Timothy D. Baker
 Donald M. Barrick
 Annie M. Bestebreurtje
 William A. Dear, Jr.
 John B. De Hoff

Lionel A. Desbordes
 Charlotte Ferencz
 Ronald H. Fishbein
 *Vincent deP. Fritzpatrick
 *Marion Friedman
 Melvin M. Friedman
 John Gambrell, Jr.
 Sheldon Goldgeier
 Susan R. Guarnieri
 *Carlton I. Halle
 *Michael G. Hayes
 *Claude D. Hill, Jr.
 John H. Hirschfeld
 Leon E. Kassel
 Samuel M. M. Lumpkin
 Joseph A. Mead
 Donald W. Mintzer
 Hiroshi Nakazawa
 Nathan E. Needle
 *Nancy T. P. Nichols
 *Gary L. Rosenberg
 W. Robert Rout
 Edward L. Suarez-Murias
 Richard M. Susel
 Thomas E. Van Metre
 Henry N. Wagner, Jr.
 *Israel H. Weiner
 Theodore H. Wilson, Jr.
 Kennard L. Yaffe

Baltimore County

Erwin Bacmeister
 Ronald L. Broadwater
 *Morton J. Ellin
 Lester N. Kolman
 John M. Krager
 Herbert J. Levickas
 David R. Morales
 J. David Nagel

William Reichel
 Margaret L. Sherrard
 Elizabeth B. Sherrill
 Adam F. Szczypinski
 Baltasar B. Velez
 Sidney J. Venable

Carroll County

*Alva S. Baker, III
 *Howard G. Lanham

Cecil County

Ernesto M. Ablang
 Mary Louise Garren

Charles County

Frederick M. Johnson
 Arturo M. Monteiro

Frederick County

*Gerald J. Schipper

Harford County

Philip W. Heuman
 Dante U. Monakil

Howard County

Thomas C. Cimonetti
 Allan T. Leffler, II

Kent County

*Robert W. Farr

Montgomery County

John G. Ball
 Ronald R. Cameron
 Marshall A. Diamond
 *Maryanna Dotson
 Michael R. Dobridge
 Robert G. Kindred
 J. Alfred Le Blanc
 Wallace H. McCune
 Jerome T. O'Connell
 Octavio Polanco
 *George J. Schonholtz
 Joseph Snyder
 *Robert F. Spicer
 Donald W. Wiczor

Prince George's County

John A. Armer
 Robert D. Gerwin
 Bruno Kolega
 Leon R. Levitsky
 Joseph J. McDonald
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MED-CHI 50-YEAR MEMBERS RECEIVED CERTIFICATES AT THE HOUSE OF DELEGATES SESSION DURING THE ANNUAL MEETING AT HUNT VALLEY INN. They are (from left to right): Drs. Clewell Howell, Richard T. Shackelford, Lawrence M. Serra, J. Arthur Weinberg, Angus L. MacLean and Eliot W. Johnson.

(Photograph by Faculty Librarian Joseph E. Jensen.)

Queen Ann's County

John R. Smith, Jr.

St. Mary's County

J. Roy Guyther

Somerset County

Eugene E. Mihalyka

Talbot County

Alfred A. Leszczynski

Washington County

Eldon L. Hawbaker

Wilfred T. Tumbusch

Wicomico County

James L. Clifford

Aubrey C. Smoot

Worcester County

Norman E. Sartorius, Jr.

Council

Albert M. Antlitz

Joseph I. Berman

Katherine H. Borkovich

John R. Davis

Edward W. Ditto, III

James D. Drinkard

Vincent J. Fiocco, Jr.

Russell S. Fisher

Robert B. Goldstein

J. Roy Guyther

William B. Hagan

Thomas F. Herbert

J. Parran Jarboe

Bernard S. Karpers, Jr.

Josn I. F. Knud-Hansen

Herbert H. Leighton

Kenneth B. Lewis

Charles H. Ligon

Emory J. Linder

Richard L. London

John T. Lynn

George S. Malouf

Francis C. Mayle, Jr.

Clarence E. McWilliams

Charles F. O'Donnell

Stephen K. Padussis

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Board of Medical Examiners

Arthur T. Keefe, Jr.

Past Presidents

Manning W. Alden

Howard F. Kinnamon

Karl F. Mech

Arthur G. Siwinski

Also present were staff personnel.

Invocation

Leslie R. Miles, MD, Chairman of the Committee on Medicine and Religion gave the invocation.

Secretary of Department of Health and Mental Hygiene

Charles R. Buck, ScD, newly-appointed Secretary of the Department of Health and Mental Hygiene, spoke briefly, calling on the physicians to cooperate with the Department and also speaking for the Department, stated similar cooperation would be forthcoming from it. He also indicated there were many problems within the Department and he looked for assistance from the physicians of the state in solving them.

President's Remarks

The President then addressed the House on the activities taking place during his term of office and the progress that had been made in the past year.

Introduction of AMA Guest

The President introduced Daniel Cloud, MD, Treasurer and member of the AMA Board of Trustees, who spoke on the

national picture and also about the AMA's activities.

Visiting State Society Presidents

The following honored guests, Presidents of the Medical Societies indicated, were introduced:

Anthony Cucuzzella, MD, Medical Society of Delaware; Charles Epps, MD, District of Columbia Medical Society; and George Nipe, MD, Medical Society of Virginia

Semiannual Minutes

The minutes of the Semiannual Session of the House of Delegates, held in Ocean City, MD, on Sept. 15, 1979, having been distributed to all members and having been corrected and approved by the Executive Committee, were presented to the House for information.

Necrology

The members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues as the Secretary read the following necrology:

Allegany County

James G. Stegmaier, MD, Sept. 8, 1978

Anne Arundel County

Samuel Borssnick, MD, May 25, 1978

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Donald S. Smith, MD, Sept. 1, 1978

Baltimore City

N. Floyd Adams, Jr., MD, Apr. 1, 1979
Thurston R. Adams, MD, July 30, 1978
Robert J. Ayella, MD, Sept. 29, 1978
Carl F. Benson, MD, Aug. 13, 1978
Joseph S. Blum, MD, May 26, 1978
Harold R. Bohlman, MD, Apr. 2, 1979
Charles R. Campbell, MD, Dec. 19, 1978
Robert L. Cavanaugh, MD, Apr. 11, 1979
Leon Donner, MD, March 4, 1979
Joseph F. Drenga, MD, Jan. 20, 1979
A. H. Finkelstein, MD, Dec. 25, 1978
Whitmer B. Firor, MD, Jan. 18, 1979
Hiram Fried, MD, Nov. 24, 1978
William L. Garlick, MD, Nov. 6, 1978
Leslie N. Gray, MD, May 1, 1978
Benjamin H. Isaacs, MD, Nov. 15, 1978
Louis F. Klimes, MD, Dec. 16, 1978
Walter Kohn, MD, March 6, 1979
Raymond E. Lenhard, MD, July 17, 1978
H. Edmund Levin, MD, May 4, 1978
Sidney Linas, MD, Sept. 7, 1978
Edmund R. Novak, MD, Apr. 11, 1979
Rafael V. Ramirez, MD, Feb. 13, 1979
Inge Renner, MD, May 29, 1978
Joseph Sindler, MD, Nov. 1, 1978
I. Ridgeway Trimble, MD, Apr. 7, 1979
D. C. Wharton Smith, MD, Jan. 1, 1979
Olive C. Smith, MD, Nov. 3, 1978

Frank B. Walsh, MD, Nov. 27, 1978
Lloyd B. Whitham, MD, March 31, 1979
Albert R. Wilkerson, MD, Apr. 11, 1978
John A. Wong, MD, March 18, 1978

Baltimore County

Philip J. Jensen, Jr., MD, Aug. 9, 1978

Calvert County

Hugh W. Ward, MD, May 26, 1978

Caroline County

Charles H. Stonesifer, MD, July 4, 1978

Dorchester County

Kenneth B. Jones, MD, Sept. 11, 1978

Howard County

Marvin F. Saiontz, MD, Feb. 15, 1979

Montgomery County

William W. Belson, MD, Dec. 11, 1978
M. McKendree Boyer, MD, Dec. 28, 1978
Harry N. Carlton, MD, Nov. 9, 1978
John C. K. Yu, MD, Jan. 12, 1979

Prince George's County

Aaron Deitz, MD, Aug. 14, 1978
Arastoo Khanizadeh, MD, Jan. 28, 1979
Edmund Rodriguez, MD, Jan. 27, 1979

Washington County

H. Edwin Blair, MD, Dec. 10, 1978
David R. Brewer, MD, Jan. 5, 1979
William C. Brewer, MD, Oct. 19, 1978

Wicomico County

Kendrick McCullough, MD, Nov. 29, 1978

Affiliates

C. William Camalier, Jr., MD, Jan. 20, 1979
Howard D. Gunlock, MD, Apr. 10, 1978

Memorial Resolutions

On motion of the Secretary, each individually, the following resolutions were adopted unanimously by the House:

M. McKendree Boyer, MD 1907-78

WHEREAS, M. McKendree Boyer, MD, of Damascus, MD, was taken from our midst on Dec. 28, 1978; and

WHEREAS, He had served his colleagues and the public in many capacities; as President of the Medical and Chirurgical Faculty, on countless Faculty and local society committees and as President of the Montgomery County Medical Society and

WHEREAS, He was loved and respected by all with whom he came into contact and

WHEREAS, His position in life will be impossible to fill and

WHEREAS, This House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland wishes to acknowledge his service to humanity therefore, be it

Resolved, That the House of Delegates goes on record as expressing its sorrow at this grievous loss to the profession and the public and

Resolved, That this resolution be spread upon the minutes of the House of Delegates meeting, May 2, 1979, and a copy be sent to Mrs. Helen Boyer, as a token of the esteem in which he was held.

Whitmer B. Firor, MD 1902-79

WHEREAS, Whitmer B. Firor, MD, one of the country's best known Radiologists, and an expert in his field, died on Jan. 18, 1979 and

WHEREAS, "Whit," as he was affectionately known by all of those with whom he came in contact, was an individual of distinction, compassion and understanding and

WHEREAS, He served as Faculty President in 1960-61, and also served in many other capacities, including the presidency of the Baltimore City Medical Society in 1958 and

WHEREAS, His death creates a void that is hard, if not impossible, to fill be it therefore

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty goes on record as noting the death of one of its distinguished members and President and be it further

Resolved, That a copy of this resolution be sent to the wife of Dr. Firor with

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an expression of condolence and sorrow and be it further

Resolved, That a copy of this resolution be spread upon the minutes of this House session held on May 2, 1979.

**Marvin Frederick
Saiontz, MD
1938-79**

WHEREAS, The Howard County Medical Society members mourn with sorrow the death of Marvin Frederick Saiontz, MD, who had been active in its affairs from October, 1973 until his death on Feb. 15, 1979 and

WHEREAS, It is the wish of the Howard County Medical Society that Dr. Saiontz be recognized for the active part he played in Faculty and local society affairs, including service as an Alternate Delegate to the Faculty's House of Delegates and

WHEREAS, It is also the wish of the Howard County Medical Society and the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland that Dr. Saiontz's memory be honored be it

Resolved, That the House of Delegates goes on record as recognizing the passing of Dr. Saiontz and

Resolved, That a copy of this resolution be spread upon the minutes of the House session on May 2, 1979, and be sent to his wife and children on this occasion.

**I. Ridgeway Trimble, MD
1900-79**

WHEREAS, I. Ridgeway Trimble, MD, passed from this mortal life on Apr. 6, 1979 and

WHEREAS, He is the son of a famous and revered physician, becoming one himself, respected and dedicated in his own time and

WHEREAS, He did much to continue the compassion, and progress commenced by his father and carried on by the son and

WHEREAS, He served in many capacities not only within the medical profession, but in areas of social concern as well as his personal life and

WHEREAS, It is the desire of the Medical and Chirurgical Faculty of the

State of Maryland that he be recognized for these accomplishments be it

Resolved, That this organization formally goes on record as noting his death and at the same time expressing its sympathy and concern to the members of his family and be it further

Resolved, That this House of Delegates notes this sad occasion and spreads upon the minutes of the meeting on May 2, 1979 this resolution, with instructions that a copy be sent to his family.

**Edmund R. Novak, MD
1916-79**

WHEREAS, Edmund R. Novak, MD, died on Apr. 11, 1979 and

WHEREAS, Dr. Novak was a distinguished physician, professor and medical author and

WHEREAS, He was held in high esteem by his fellow-physicians, educators and the public and

WHEREAS, He came from a line of distinguished physicians, all of whom have left to their memory outstanding milestones in the practice of medicine and

WHEREAS, Dr. Novak will be sorely missed from the community and his position will be hard, if not impossible to fill and

WHEREAS, It is the desire of his colleagues that recognition be given to him by a memorial in the minutes of the House of Delegates of the Medical and Chirurgical Faculty for the contributions he made during his lifetime therefore, be it

Resolved, That this resolution be spread upon the minutes of the May 2, 1979, House session of the Faculty and a copy be sent to his relatives.

50-Year Members

Presentation of 50-year certificates and pins to the following members then took place, with the awards being mailed to those unable to attend the meeting:

Baltimore City

William W. Elgin, MD
Lewis P. Gundry, MD
Eliot W. Johnson, MD
Angus L. MacLean, MD
Lawrence M. Serra, MD

Richard T. Shackelford, MD
J. Arthur Weinberg, MD

Baltimore County

Clewell Howell, MD

Dorchester County

John Mace, Jr., MD

Montgomery County

J. Marion Bankhead, MD

Washington County

Henry F. Graff, MD

Emeritus Membership

On motion of Vincent J. Fiocco, Jr., MD, Council Chairman, the following members were elected to Emeritus Membership in the Faculty, each having received the recommendation of their Component Societies and the Council:

Anne Arundel County:

William P. Stephens, MD, Annapolis
Baltimore City:

Mitchell H. Miller, MD, Baltimore
Alice B. Tobler, MD, Baltimore
Daniel G. Wehner, MD, Baltimore
Jack Wexler, MD, Longboat Key, FL
James E. White, MD, Baltimore

Baltimore County:

Ruth M. Allen, MD, Phoenix, MD

Montgomery County:

Frank Abrams, MD, Bethesda
Philip E. Jones, MD, Silver Spring
Reginald H. Mitchell, MD, Rockville

Prince George's County:

Edward Gartman, MD, Laurel
Rowland F. Wilkinson, MD, Riverdale

Treasurer's Report

Robert B. Goldstein, MD, Treasurer, made a brief report on the 1979 budget as approved by the Council, which had been distributed to all members prior to the meeting.

Bylaws Committee Report

John G. Ball, MD, Bylaws Committee Chairman, on behalf of the Bylaws Committee moved adoption of the following bylaw amendments, which by unanimous consent were considered together and,

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after debate, on a division vote were adopted by greater than the 2/3 vote required:

(a) Amend Article IV, (Officers), Section 3, by striking out "15 days" and inserting "30 days."

(b) Amend Article IV, (Officers), Section 6, by adding the following sentence: "Councilors in each newly elected annual class shall assume their duties at the close of the Annual Session, immediately preceding which they were elected."

Dr. Ball, on behalf of the Bylaws Committee, moved adoption of the following bylaw amendment which, after debate, on a division vote, was adopted by greater than the 2/3 vote required:

Amend Article XI (Committees), Section 6, by substituting for it the following: "Section 6—A Medical Economics Committee of at least five members shall be appointed annually. It shall constantly review existing membership benefits other than insurance plans, making an annual report to the House of Delegates together with any recommendations it may have. It shall investigate new member benefit programs, (except for member insurance benefits), determine their acceptability to the members and proceed with implementation of the programs approved by the Faculty's governing bodies. Once such a program has been implemented, it shall be turned over to the committee of the Faculty charged with this responsibility or to the Med-Chi Services Agency, Inc., for operational purposes. Its chairman shall be appointed by the President and said Chairman shall appoint the other members of the committee with the approval of the President."

Dr. Ball, on behalf of the Bylaws Committee, moved adoption of the following bylaw amendment which, after debate and amendment, was adopted, on a division vote, by greater than the 2/3 vote required:

Amend Article XI (Committees), by substituting for Section 16 the following: "Section 16-A Legislative Committee shall consist of at least five members appointed by the President, one of whom the President shall designate as chairman, together with one member of each component society and specialty society, recognized by the Faculty, chosen by those societies annually. The Maryland State Dental Association shall have the right to choose one associate member of the committee with voice but without vote. The committee shall inform itself on all legislation, national, state and local, affecting the practice of medicine; advise the Faculty when necessary in regard to such legislation; and with the President or such other person as the Council or House of Delegates may name, represent the Faculty before any legislative body when required."

Bylaws Committee Instruction

Dr. Anderson, on behalf of the Baltimore City Delegation, offered a motion

that the Bylaws Committee consider and report an amendment to Article XI, Section 16, to require that "Voting members of the Legislative Committee be Active members of the Faculty in good standing." The motion was adopted.

Nominating Committee Report

John R. Davis, Chairman of the Nominating Committee, presented the following slate to the House of Delegates:

President-Elect

Vincent J. Fiocco, Jr. (President-Elect 1979-80; President 1980-81)

First Vice President

George S. Malouf, Hyattsville

Second Vice President

J. Roy Guyther, Mechanicsville

Third Vice President

Herbert H. Leighton, Oakland

Secretary

Bernard S. Karpers, Jr., Baltimore

Treasurer

Robert B. Goldstein, Baltimore

Committee on Program and Arrangements

(1979-82) Alva S. Baker, Westminster

(1980-84) Morton I. Rapoport, Baltimore

Library and History Committee

(1980-85) Eldon L. Hawbaker, Hagerstown

Finney Fund Committee

(1980-85) A. McGeehe Harvey, Baltimore

Board of Medical Examiners

(June, 1979 - June, 1983)

Chris Papadopoulos, Baltimore

(June, 1979 - June, 1983)

Manning W. Alden, Annapolis

Delegates and Alternates to the AMA

Delegate: Charles F. O'Donnell, Towson

(Jan. 1, 1980 - Dec. 31, 1982)

Alternate: Robert B. Goldstein, Baltimore

(Jan. 1, 1980 - Dec. 31, 1982)

Alternate: Francis C. Mayle, Jr., Bethesda

(May 5, 1979 - Dec. 31, 1981)

Nominations Closed

The floor was opened to further nominations for these offices and there were no nominations made. Nominations were closed by general consent. It was announced that the Board of Medical Examiners are to be elected at the General Session, May 3, 1979 at noon, at the Hunt Valley Inn, Hunt Valley, MD and the election of other positions will take place at the second meeting of the session, May 5, 1979 at 9 AM.

(Continued on page 53)

Tenuate®
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Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors. (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomeastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypotension, if this complicates Tenuate overdose.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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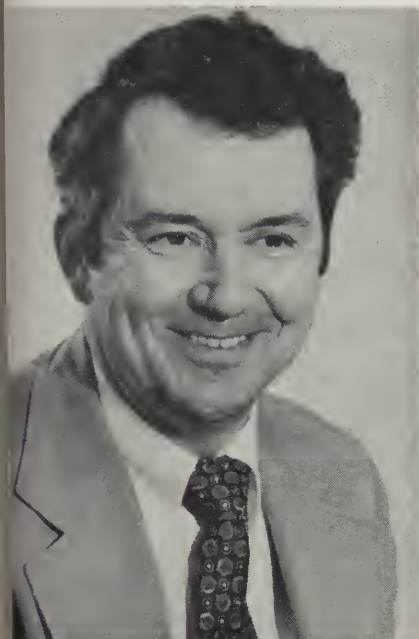
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J-6999-4

April 1979

There being no further business, by general consent, the President declared the meeting adjourned at 11:45 AM until May 5, 1979 at 9 AM at the Hunt Valley Inn.

BERNARD S. KARPERS, JR., MD,
Secretary



BERNARD S. KARPERS, JR., MD
Faculty Secretary, 1979-80

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MINUTES

Second Meeting 181st Annual Session House of Delegates (297th Meeting) Medical and Chirurgical Faculty of the State of Maryland May 5, 1979

Hunt Valley Inn, Hunt Valley, MD

The 297th meeting, second of the 181st Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:15 AM, May 5, 1979, at the Hunt Valley, MD, the President and Secretary being present.

The following Delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors

Allegany County

Leslie R. Miles, Jr.
*Michael F. Whitworth

Anne Arundel County

Nicholas A. Capozzoli
Leo A. Courtney
Charles R. MacDonald
David S. McHold

Baltimore City

Ian R. Anderson
Shahid Aziz
Donald M. Barrick
Annie M. Bestebreurtje
John B. De Hoff
Charlotte Ferencz
Elliott R. Fishel
*Vincent deP. Fitzpatrick
*Carlton I. Halle
*Leonard G. Hamberry
*Michael G. Hayes
John H. Hirschfeld
*Frank L. Iber
Samuel M. M. Lumpkin
Donald W. Mintzer
John H. Mulholland
Nathan E. Needle
*Nancy T. P. Nichols
*Allan S. Pristoop
*William F. Renner
*Gary L. Rosenberg
W. Robert Rout
Patricia M. Smith
Edward L. Suarez-Murias
*Richard L. Taylor
Thomas E. Van Metre
*Israel H. Weiner
Kennard L. Yaffe
*Lois A. Young

Baltimore County

Erwin Bacmeister
*John W. Buckley
*Esther Edery
*Charles M. Kerr
Lester N. Kolman
John M. Krager
Herbert J. Levickas
David R. Morales
William Reichel
Margaret L. Sherrard
Elizabeth B. Sherrill
Baltasar B. Velez
Sidney J. Venable

Carroll County

Reynaldo P. Madrinan
Daniel I. Welliver

Harford County

*Rosemary H. Bonsack
Ben E. Oteyza

Howard County

Thomas C. Cimonetti

Kent County

*Robert W. Farr

Montgomery County

John G. Ball
*DeWitt E. DeLawter
Marshall A. Diamond
Robert G. Kindred
John A. McCormack
Joseph Snyder
Thomas M. Wilson

Prince George's County

John A. Armer
Leon R. Levitsky
Joseph J. McDonald
Steven C. Sandler
Henry A. Wise

Somerset County

Eugene E. Mihalyka

Talbot County

Alfred A. Leszczynski

Washington County

Wilfred T. Tumbusch

Wicomico County

Aubrey C. Smoot

Council

Albert M. Antlitz
John R. Davis
James D. Drinkard
Vincent J. Fiocco, Jr.
Russell S. Fisher
Robert B. Goldstein

Thomas F. Herbert
J. Parran Jarboe
Carol J. Johns
Bernard S. Karpers, Jr.
Herbert H. Leighton
Emory J. Linder
John T. Lynn
George S. Malouf
Francis C. Mayle, Jr.
Charles F. O'Donnell
Stephen K. Padussis
William S. Pillsbury

Board of Medical Examiners

Arthur T. Keefe, Jr.

Past Presidents

Manning W. Alden
Karl F. Mech
Present also were staff personnel.

Election of Officers

The President advised the members that the following had been elected to the Board of Medical Examiners at the General Session held on May 3, 1979 at the Hunt Valley Inn, at Noon:

Manning W. Alden, MD, Annapolis
(June, 1979 - June, 1983)

Chris Papadopoulos, MD, Baltimore
(June, 1979 - June, 1983)

There having been no nominations from the floor and there being only one candidate for each office to be filled, by

unanimous consent, the ballot was dispensed with. The following were then elected by acclamation:

President-Elect

Vincent J. Fiocco, Jr. (President-Elect 1979-80) (President 1980-81)

First Vice President

George S. Malouf, Hyattsville

Second Vice President

J. Roy Guyther, Mechanicsville

Third Vice President

Herbert H. Leighton, Oakland

Secretary

Bernard S. Karpers, Jr., Baltimore

Treasurer

Robert B. Goldstein, Baltimore

Committee on Program and Arrangements

(1979-82) Alva S. Baker, Westminster
(1980-84) Morton I. Rapoport, Baltimore

Library and History Committee

(1980-85) Eldon L. Hawbaker, Hagerstown

Finney Fund Committee

(1980-85) A. McGehee Harvey, Baltimore

Delegates and Alternates to the AMA Delegate: Charles F. O'Donnell, Towson

(January 1, 1980-December 31, 1982)

Alternate: Robert B. Goldstein, Baltimore

(January 1, 1980-December 31, 1982)

Alternate: Francis C. Mayle, Jr., Bethesda

(May 5, 1979-December 31, 1981)

MMPAC Report

Richard F. Moschell, MD, Chairman of the Maryland Medical Political Action Committee, made a report to the House which is included in the Annual Reports.

Auxiliary Report

Mrs. Kassie Herbert, Auxiliary President, made a verbal report to the House and her remarks will be contained in the Annual Reports.

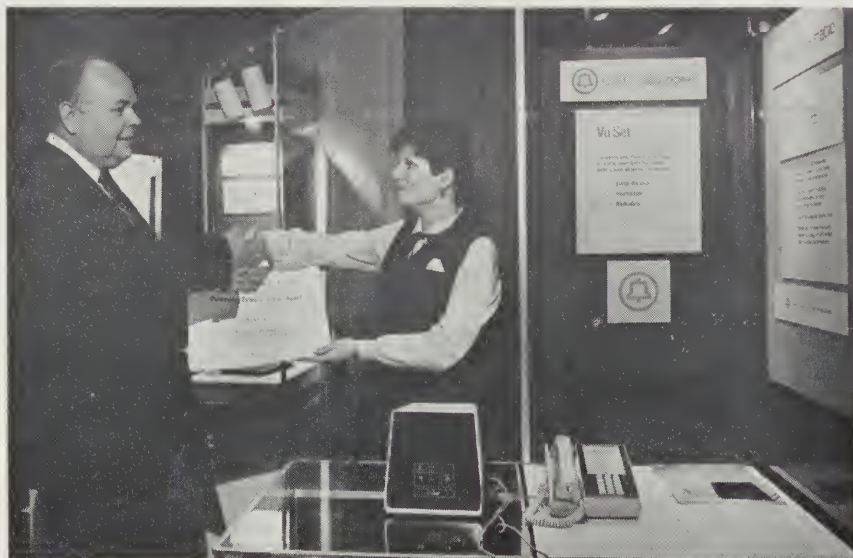
Resolution 1A/79 Adopted as Amended

The Secretary reported Resolution 1A/79 offered after the deadline by Dr. Mulholland, on behalf of the Baltimore City Medical Society Delegation. There being 2/3 in favor on a division vote, the House ordered that Resolution 1A/79 be considered. After debate and amendment, Resolution 1A/79, was adopted as follows:

WHEREAS, Alcoholism is a leading cause of morbidity and mortality in the State of Maryland and

WHEREAS, It is reported that from 10-13% of the citizens of Maryland suffer from alcoholism, which disease has been declared by the City of Baltimore to be its major public health problem and

WHEREAS, Most alcoholics (97%) are employed or are employable, reside with



FIRST PLACE AWARD FOR A TECHNICAL EXHIBIT AT THE ANNUAL MEETING AT HUNT VALLEY INN went to the Chesapeake and Potomac Telephone Co., and was presented by Dr. Herbert J. Levickas, Med-Chi Program Committee Chairman (left) to Marion Connolly Zipfel.
(Photo by Tadder, Balto.)



SECOND PLACE AWARD FOR A TECHNICAL EXHIBIT AT THE FACULTY'S ANNUAL MEETING AT HUNT VALLEY INN went to Roche Laboratories. Seen from left to right are: Program Committee Chairman Dr. Herbert J. Levickas presenting the Award to Roche staffers Ron Hardnock, Archie Baluyut and Vaseem Iftekhar.
(Photo by Tadder, Balto.)

their families and are covered by some form of health insurance which, in most instances, does not cover treatment for alcoholism as such and

WHEREAS, Treatment of alcoholism itself is more cost-efficient than treatment for those end stage diseases resulting from chronic alcoholism and

WHEREAS, A recent study of major industries in other states where insurance coverage is provided for alcoholism treatment shows savings of 55% in health insurance expenditures for medical conditions caused by untreated alcoholism and

WHEREAS, Some health insurance carriers in Maryland offer coverage for such treatment in their group policies but few groups purchase this option and

WHEREAS, Alcoholism has been declared an illness with psychologic and organic factors by the American Medical Association and by the Medical and Chirurgical Faculty of the State of Maryland and is so listed in ICD-9-CM and CPT-4, yet major insurance carriers utilize only psychiatric fiscal criteria in computing costs of alcoholism coverage therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland goes on record as urging all health insurance carriers doing business in this State to provide coverage for inpatient, residential and outpatient treatment of alcoholism as a basic benefit in its contracts and be it

Resolved, That although it is recognized benefits for alcoholism treatment cannot become a part of the basic benefit insurance package immediately, health insurance carriers are urged to aggressively market the alcoholism treatment benefit option in all policies currently sold in Maryland and be it

Resolved, That all health insurance carriers be urged to change their procedures so that alcoholism is underwritten as a medical condition and be it

Resolved, That copies of this resolution be sent to Maryland Blue Cross, Inc., Maryland Blue Shield, Inc., the Health Insurance Association of America, the Maryland Chamber of Commerce and the State Insurance Commissioner.

Transfer of Office

There being no further business to come before the House, the President turned the gavel over to the incoming President, William A. Pillsbury, Jr., MD, who called upon John R. Davis, MD, Immediate Past President, to present to the outgoing President a medallion and ribbon as a memento of his term of office.

The House rose and gave a standing ovation to Dr. Mayle, as he retired from the podium.

There being no further business to come before the House, by unanimous consent, it adjourned sine die at 9:45 AM.

BERNARD S. KARPERS, JR., MD,
Secretary



Discipline
Commission
Findings appear
monthly in
the JOURNAL.

AWARDED FIRST PRIZE FOR A TV TALK SHOW BY THE AMA NATIONAL LEADERSHIP CONFERENCE was **DR. RAYMOND J. DONOVAN, JR.** (left, with Award being presented in the Faculty's Osler Hall by President-Elect Vincent J. Fiocco, Jr., MD.)

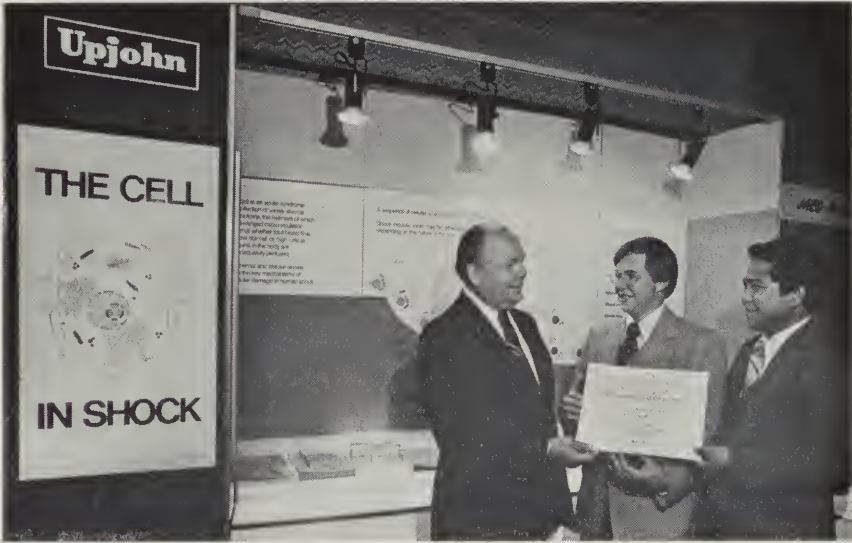
(Photo by Faculty Librarian Joseph Jensen.)

For the latest information on Med-Chi Annual and Semi-annual Meetings, read the Journal every month!

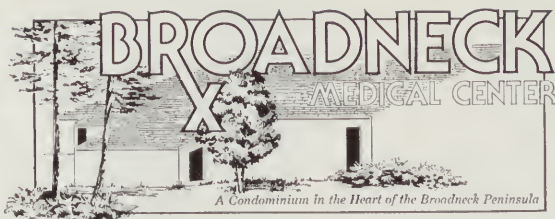
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THIRD PLACE AWARD FOR A TECHNICAL EXHIBIT AT THE ANNUAL MEETING AT HUNT INN went to the Upjohn Co. Presenting the Award was Faculty Program Committee Chairman Herbert J. Levickas, MD (left) to John Burgess (center) and Simeon Santos (right.)
(Photo by Tadder, Balto.)



Planned for the Medical Professional

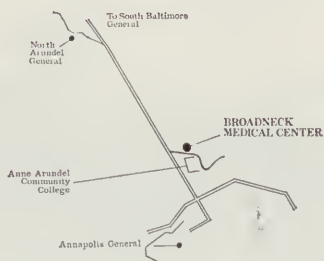
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Doctors Take Note:

Sept. 18—Current Concepts in Diagnosis and Treatment of Retinal and External Ocular Disease, Univ. of MD Sch. of Med. Campus, Balto. For further info, contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

REPORT OF THE FACULTY'S DELEGATES TO THE AMA HOUSE OF DELEGATES DEC. 3-6, 1978

Mr. President and Members of the House of Delegates:

The Interim Meeting of the American Medical Association's House of Delegates, which concluded in Dec. 6, 1978, begins a policy whereby Interim Sessions will be held in December, but will be rotated to different locations throughout the United States. Annual Sessions will consistently be held in Chicago.

The AMA House currently consists of 271 delegates from 55 states and territories and more than 50 national specialty societies. The House also includes one voting delegate from the medical students, housestaff, medical schools and the services, i.e., the Army, Air Force, Navy, VA and Public Health Service. About 200 items of business were considered and this particular meeting presented many difficult and far-reaching decisions for your delegates. Those actions will have a decided impact on the future course of the Association and on each individual physician.

As has been the custom, members of the Faculty delegation to the AMA and staff were assigned to various Reference Committees. All physicians, whether AMA members or not, may speak to issues coming before such Reference Committees. As usual, debate was intense on some issues, and, in some cases, the Committees deliberated until the early hours of the morning. The Reference Committees and the House Sessions offered every opportunity for open discussion on the national issues affecting each individual physician.

Chiropractic

The AMA is currently involved in three litigation issues regarding Chiropractic. The Pennsylvania suit is filed as a class action on behalf of all chiropractors who are seeking freedom to gain access to laboratory and radiology facilities and services, and to have reports on such diagnostic procedures performed for their patients in their order. The Pennsylvania suit charges the AMA and several other organizations with conspiracy to prevent chiropractors from practicing their profession as provided by state law.

After much time and legal expense, all parties had agreed to settle the suit except the Pennsylvania Radiological Society and the American College of Radiology. In an effort to delay the settlement, two delegates, at the request of four specialty organizations, filed suit challenging the authority of the Board of Trustees to enter into a settlement agreement without concurrence by the House of Delegates.

In a rare closed meeting of the House, consideration of several resolutions regarding this issue were held. The House

acknowledged and affirmed the authority of the Board of Trustees to settle the lawsuit. The House also called on the AMA to "Continue to warn the public of hazards to health of entrusting the diagnosis and treatment of diseases such as cancer, diabetes, malignant hypertension, cardiovascular stroke and infections to practitioners who, in the treatment of these conditions, rely upon the theory that all disease is caused by misalignment of spinal vertebrae and can be cured by manual manipulation of the spine." In related action, the House also supported the physician's right to exercise this choice by the terms of contractual arrangements with other physicians, medical groups, hospitals or other institutions. It was also stated that a physician's obligations to provide information to a patient or any other party are those required by customary good medical practice and law. The Judicial Council was requested to reconsider Article 3.70 of Section III of Judicial Council *Opinions and Reports*. This Article states that physicians may accept or decline patients sent to them by limited practitioners or by laymen. It also states the role of specialists in providing information to such patients if they choose to provide services. It is emphasized that none of these actions should be construed as an amendment to the AMA's Principles of Medical Ethics.

We left the Chicago meeting hoping the misunderstandings surrounding the controversy had been resolved and that the damaging divisiveness generated by this highly-emotional issue was behind us.

National Health Insurance

The Association's position on NHI was once again a major topic for debate. Looking ahead to the new Congress and expiration of all current NHI proposals, the delegates considered several resolutions and reports to establish current AMA policy.

In a major change in policy, the House turned down the recommendation of the Association's board and Councils on Legislation and Medical Service and the Reference Committee that the AMA introduce into Congress early next year the "Health Insurance Improvement Act of 1979." This proposal would have marked the ninth consecutive year the AMA has had before Congress a bill to provide basic insurance benefits for all Americans, and the Reference Committee urged the House to approve it, citing that, "It is essential for the Association to continue to have before the Congress—in the interest of the public—a proposal offering a private sector approach building on the strengths of our present health care delivery system."

In final action on the NHI issue, the House voted to recommend to Congress modifications of the health care system and that the AMA sponsor legislation, if necessary, embodying these principles:

1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with

appropriate deductible and coinsurance.

2. A simple system of uniform benefits provided by the Federal, State and local governments for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.

3. A nationwide program by the private insurance industry of America (and government, if necessary, for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and co-insurance to make it economically feasible and to avoid abuse.

4. A program developed pursuant to these principles should be administered at the state level with national standardization through Federal guidelines.

Medical Ethics

The proposed revision of the Principles of Medical Ethics continues to receive much attention from members of the House. At the Annual Meeting in June, the House established an ad hoc committee to give the proposal more study and to present its recommendations to the House. At the Interim Meeting, the ad hoc committee reported that it was not yet prepared to make a final report and asked for authorization to continue its work for a report at the 1979 Annual Meeting. The House granted the Committee the additional time.

Second Opinions

By adopting a report from the Council on Medical Service, the AMA went on record opposing the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion. The House reaffirmed policy that supports the concept that, when a second opinion is required by a third-party payor, that opinion should be at no cost to the patient. The delegates also reaffirmed the right of a patient or a physician to seek a second opinion freely from any physician of his/her choice.

The report concluded that the Council on Medical Service has been no conclusive evidence that these programs will overcome the long run favorable impact on the quality, appropriateness and the accessibility or costs of care.

Voluntary Effort

The cost of medical care and the profession's commitment to restrain cost increases was a theme of several reports and resolutions. Many of these reports were stimulated by the recommendations of the National Commission on the Cost of Medical Care and AMA President Dr. Tom E. Nesbitt's call for voluntary restraint in physician fee increases. In a series of actions directed at controlling costs, the House of Delegates urged hos-

pital medical staffs to establish standing committees to provide recommendations for cost containment without compromising quality care. A recommendation was directed to the Carter Administration asking that the government contain health care costs by reducing the number of regulations. The expanded study by the Health Insurance Industry of the effects of cost-sharing of benefits on both consumer and provider behavior was encouraged. Finally, the House urged all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records so that the hospital physicians sharing in the care of those patients can practice more effective and better medical care.

Miscellaneous Business

With concern for fundamental fairness

and rudimentary procedural protection, a resolution was adopted which provides for the development of Guidelines for Due Process. These guidelines will be designed specifically for physicians for use in various situations encountered in hospitals, medical schools, medical societies and other areas.

In the area of Health Planning, there was support for the development of rational criteria by state and local planning bodies for placement of expensive facilities and equipment. If national guidelines are developed to assist states and localities in such activity, the guidelines should be advisory and should be developed only with the cooperation of physicians and other health professionals.

Preventive health measures and health education received continued endorsement by the adoption of various resolutions

from state medical associations. The House of Delegates voted to commemorate the International Year of the Child (1979) by endorsing the use of seatbelts and other vehicular restraints for infants and children. A proposal for expansion of child immunization programs generated considerable debate because of a provision that a compensation mechanism should be developed for patients who suffer vaccine-related injuries. This resolution, which proposed immunity from liability for those who administer vaccinations, as well as the manufacturer of vaccinations, was referred to the Board of Trustees for further study.

Confusion over whether state medical associations have authority to accredit continuing Medical Education programs was clarified with endorsement by the House of Delegates of statewide accreditation by state medical organizations. The AMA affirmed the concept of accreditation of CME programs by state associations whose CME standards meet those of the AMA or the standards of the Liaison Committee on CME. Subsequently, this will require changes in LCCME bylaws allowing accrediting by state societies with such standards meeting AMA approval.

In an attempt to address the serious problem of increased government regulations, the House voted to establish a public forum, in cooperation with other interested groups, to develop methods of minimizing government involvement and the subsequent deleterious effect on the American public.

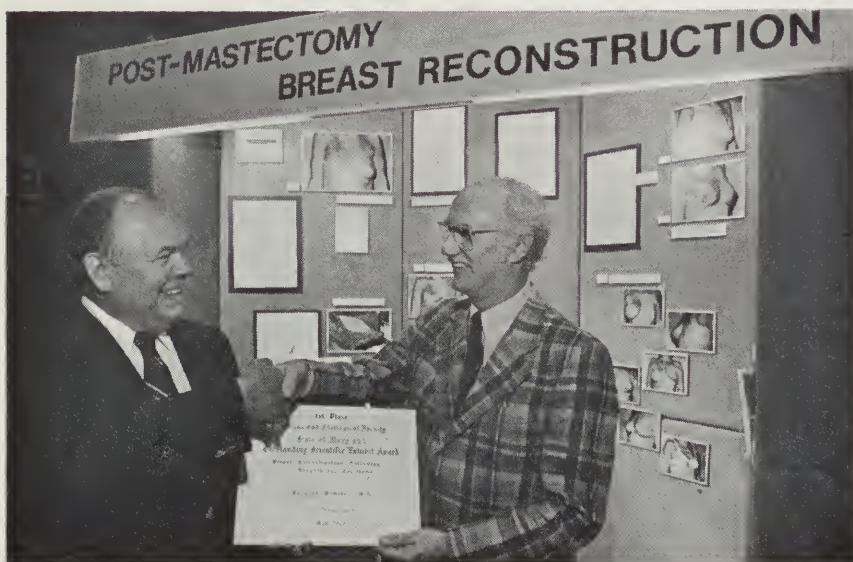
The AMA continues in its excellent financial position and bases this success on strong financial performance and control; however, the Reference Committee alerted the House to the approach of 1981 when, at the current level of AMA activity and projected rates of inflation, expenses will begin to exceed income. This pattern was projected in the financial plan of 1975 and it appears that the AMA may not be able to avoid a dues increase in 1981. The leaders of state and county medical societies are urged to address the challenges of membership recruitment with new urgency and purpose during the coming year. Only 1,300 physicians became new full dues-paying members during 1978; however, an encouraging factor in membership recruitment is the continued increase in the number of medical students and residents who are joining the AMA.

Your Delegates and Alternate Delegates urge that you relate to us your viewpoint on the issues affecting your practice so that these can be brought to the House.

RUSSELL S. FISHER, MD
CHARLES F. O'DONNELL, MD
STEPHEN K. PADUSSIS, MD
MANNING W. ALDEN, MD
ROBERT B. GOLDSTEIN, MD

Doctors Take Note:

Sept. 14, 15, Symposium Lung Disease. Guest lecturers include Thomas L. Petty, MD, Denver CO; David V. Bates, MD, Vancouver BC Canada; Marvin Sackner, MD, Miami, FL. For more info, contact Velma Rector, Amer. Lung Assn. of MD (301) 685-6484.



FIRST PLACE AWARD FOR A SCIENTIFIC EXHIBIT AT THE ANNUAL MEETING AT HUNT VALLEY INN went to Dr. Bernard M. McGibbon, and was presented by Program Committee Chairman Herbert J. Levickas, MD (left.) (Photo by Tadder, Balto.)



SECOND PLACE AWARD FOR A SCIENTIFIC EXHIBIT AT THE ANNUAL MEETING AT HUNT VALLEY INN went to the Taylor Medical Group, PA for **Biofeedback**. Presenting the Award to Dr. Ronald J. Taylor (right) was Herbert J. Levickas, MD, Faculty Program Committee Chairman. (Photo by Tadder, Balto.)

LEGISLATIVE 1978-79

Mr. President and Members of the House of Delegates:

The 1979 session of the Maryland General Assembly studied a number of issues that have been considered in the past. Because the entire Legislature stood for election in 1978, there were no summer hearings and a short, 30-day prefilming period just prior to the opening of the session in January, 1979. Many of the new legislators showed both a lack of depth in medical issues and a hostility toward the profession. Physicians as a group were often criticized for failing to be responsive to their patients. The Committee developed, introduced and testified on several bills this year. The major ones are listed herein.

HSCRC

The Faculty sponsored legislation which would have clearly stated that the Health Services Cost Review Commission has no jurisdiction over the physicians' services, tenure, compensation or fees. The Senate amended the bill on the floor adding, "unless, and to the extent the compensation or fees are established by the hospital, for services which are traditionally provided by the hospital or are administrative in nature." The bill, amended to include this language, was unacceptable to the Faculty. After passing the Senate, the bill failed in the House Environmental Matters Committee.

Physicians-Specialization Advertising

After several years of development, a bill was introduced providing that physicians who wish to be identified as specialists submit their qualifications to the Board of Medical Examiners. Upon acceptance of the credentials, the Board will issue a certificate of identification. The bill was enacted and will take effect July 1, 1980.

Indoor Air Preference Act

The Preventive Medicine and Public Health Committee provided the impetus for this bill, which was introduced in both houses of the Legislature. The bill required smoking and nonsmoking areas be delineated in all indoor public areas. For the first time in Maryland, the bill was passed by the Senate; however, it failed in the House of Delegates.

Right to Die

The Maryland Legislature once again considered this measure which would establish a "living will" for patients. The bill failed in the Senate Finance Committee. Faculty members testified to the effect that the final decision rests with the physician, patient and family at the time of necessity, rather than prospectively.

Ophthalmological Legislation

Optometrists worked very hard to pass legislation which would permit the use of diagnostic agents in the eye. After very intense legislative activity on both sides, the bill passed the Senate, but failed in the House Environmental Matters Committee. Ophthalmologists introduced a bill that would have required optometrists to refer any patient with vision uncorrectable to 20/40 to a physician. This bill failed in the House committee where it was introduced.

Allied Health Personnel

Nurse practitioners won the right to be reimbursed by third-party payors on an optional basis in a bill worded much the same as the bill passed in 1978 providing for benefits for nurse midwives. Insurance companies may require the nurse practitioner to work under the supervision of a physician. Podiatrists petitioned for a change in the definition of their practice. As a result, they will be able to amputate toes, but still must refrain from using anesthetics, performing tarsal osteotomies and triple arthrodesis. In another action, hospitals which render medical or surgical care of the foot will have to amend bylaws to allow podiatrists to apply for staff privileges. Psychologists, jointly with psychiatrists, will be permitted to admit patients to hospitals. Physical therapists will no longer be required to see patients only on referral but when referred, must act within the orders of the referring physician.

Gun Control Legislation

At the request of the Faculty's House of Delegates, the Committee met on July 19th to discuss the possibility of introducing legislation to limit the use of hand-

guns in Maryland. Following testimony presented to the Committee, they met and recommended that "Since there are sufficient laws on the books already involving gun control, the Legislative Committee recommends that there is no need for this resolution." This conclusion was submitted to the House of Delegates at the Semiannual Meeting in September. The House upheld the recommendation of the Committee.

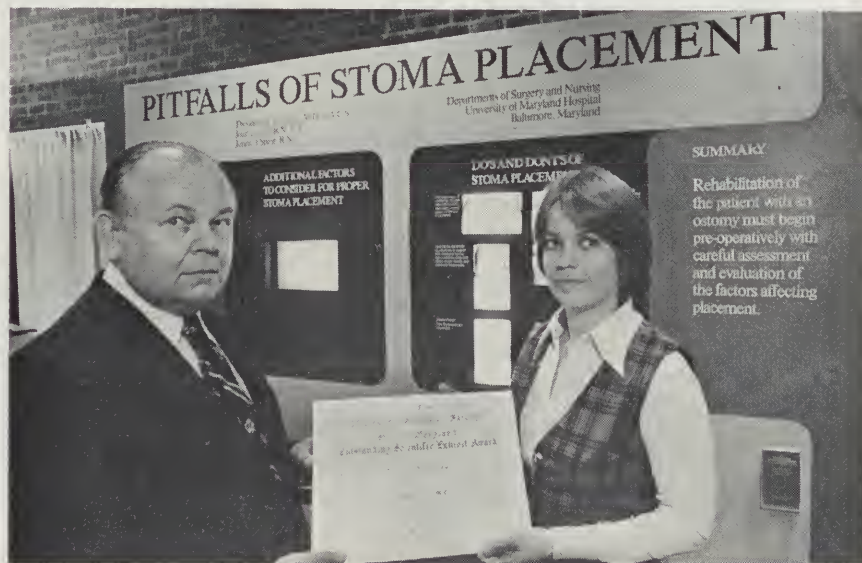
Legislative Communications

The periodic conference call with representatives from throughout the state was replaced by a weekly newsletter called the *Assemblyman Update* which was mailed to Legislative Committee members, Chairmen of Faculty committees, officers and others. The *Update* edition seemed to be a very successful tool for communication among Faculty members. In addition, three issues of the *Assemblyman* were published and an *Assemblyman Supplement*, listing final action on all bills monitored by the Faculty during the legislative session. The telephone Hot Line daily tape-recorded messages about current legislation and was in service throughout the session; however, the number of calls received dropped substantially on the two statewide WATS line.

First-Aid Room

Once again, the Maryland Academy of Family Physicians provided medical coverage for the First-Aid Room in Annapolis. The facility was staffed full-time by nurses Rose Argiro and Carolyn McCoy. A total of 953 patients was seen and 58 physicians volunteered their time to serve.

The Chairman extends his grateful thanks both to the members of the Committee for their continued interest and



THIRD PLACE AWARD FOR A SCIENTIFIC EXHIBIT AT THE ANNUAL MEETING AT HUNT VALLEY went to *Pitfalls of Stoma Placement*, from the University of Maryland's Departments of Surgery and Nursing. Accepting the Award from Dr. Herbert J. Levickas, Med-Chi Program Chairman, (left) was Jennifer Spear, RN.

(Photo by Tadder, Balto.)

service and to the many physicians who willingly and patiently gave their time to consult with the committees and members of the Maryland General Assembly.

STEPHEN K. PADUSSIS, MD, Chairman
MANNING W. ALDEN, MD
J. ANDREW ARMER, MD
THOMAS C. CIMONETTI, MD
MRS. DeWITT DELAWER
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WILLIAM H. KIRBY, JR., MD
JOSE MARTINEZ, MD
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RAYMOND P. SRIC, MD
WILLIAM A. WARREN, MD
ISRAEL WEINER, MD

LIAISON COMMITTEE WITH DEPARTMENT OF HEALTH AND MENTAL HYGIENE ON MEDICAID PROGRAM

*Mr. President and Members of the House
of Delegates:*

This past year continued to be one of frustration for members of your Commit-

tee. Progress is agonizingly slow in moving the bureaucracy to work. The only concrete accomplishment that can be pointed to this year is adoption by the Medicaid program of the Current Procedural Terminology Codes for Medicaid billing purposes. Over 2,000 individual copies of the AMA CPT-4 Guide have been made available to physicians and others throughout the state in order to effect this conversion. The main objective of the AMA CPT-4 guide in the Medicaid system is to provide statistical data and to assist in changes in fee payments.

Problems involving the following areas were satisfactorily resolved with all parties:

1. Definition of Physician/Consultant under the program
2. Regulation on payment of X-rays in the practicing physician's office
3. Agree to a ban on anorectic drugs for weight-control in Medicaid patients
4. Agreed to the utilization of private practicing pediatricians in the EPSDT program
5. Resolved a problem involving payment to podiatrists for services they are authorized to perform under law so that physicians would be paid no less than the podiatrists are paid.
6. The Carroll County Study involving primary care at 80% of the usual and customary fees has not produced significant data to date. Unfortunately at the

time of this report, this program will not be funded by the Department of Health, Education and Welfare.

Payments under the Medicaid program to physicians in Maryland continue to be among the lowest in the entire United States. Despite our attempts to improve this by meeting with the Budget Bureau, the Secretary of the Department of Health and Hygiene and Ms Ann Hull, the Governor's Consultant on Health and Women, we can see no visible route to improvement, other than the current increase in office visit fees to \$8 per visit. Adjustments are made in fees for surgery and other procedures as funds become available for this purpose.

It is heartening to know, however, that the Conference for Social Concern and the Central Maryland HSA have both gone on record as urging an upgrading in the private physicians' office visit fee. These groups recognize that patients will continue to be seen in hospital settings at charges ranging as high as \$60 per visit unless and until the program provides payment on a reasonable basis.

Despite the difficulties encountered, your Committee will continue to work towards an effective method of reimbursement that will attract the largest number of physicians to participate, consistent with the high quality of medical care provided to Maryland citizens.

KARL M. GREEN, MD
Chairman

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NOMINATIONS FOR 1980

Mr. President and Members of the House of Delegates:

(Those elected will assume office at the conclusion of the Annual Meeting, 1980, unless otherwise indicated. All are MDs.)
For presentation to the House of Delegates, May 2, 1979:

President-elect

VINCENT J. FIOCCO, JR., (President-Elect 1979-80)
(President 1980-81)

First Vice President

GEORGE S. MALOUF, Hyattsville

Second Vice President

J. ROY GUYTHER, Mechanicsville

Third Vice President

HERBERT H. LEIGHTON, Oakland

Secretary

BERNARD S. KARPERS, JR., Baltimore

Treasurer

ROBERT B. GOLDSTEIN, Baltimore

Committee on Program and Arrangements (1979-82) ALVA S. BAKER, Westminster

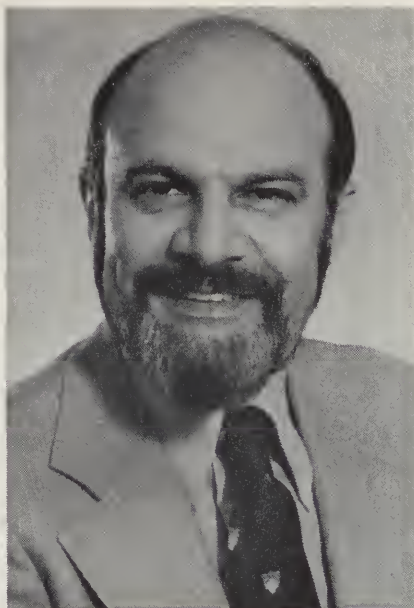
(1980-84) MORTON I. RAPOPORT, Baltimore

Library and History Committee

1980-85) ELDON L. HAWBAKER, Hagerstown

Finney Fund Committee

1980-85) A. McGEHEE HARVEY, Baltimore



VINCENT J. FIOCCO, JR., MD
Faculty President-Elect, 1979-80
(Photo by Tadder, Balto.)

Board of Medical Examiners

(June, 1979 — June, 1983)

CHRIS PAPADOPOULOS, Baltimore

(June, 1979 — June, 1983)

MANNING W. ALDEN, Annapolis

Delegates and Alternates to the AMA

Delegate: CHARLES F. O'DONNELL, Towson

(Jan. 1, 1980 — Dec. 31, 1982)

Alternate: ROBERT B. GOLDSTEIN, Baltimore

(Jan. 1, 1980 — Dec. 31, 1982)

Alternate: FRANCIS C. MAYLE, JR., Bethesda

(May 5, 1979 — Dec. 31, 1981)

Nominating Committee:

JOHN R. DAVIS, MD, Baltimore, Chairman

ARIS T. ALLEN, MD, Annapolis, Southern District

ELLIOTT R. FISHEL, MD, Baltimore, Central District

LEON R. LEVITSKY, MD, Mt. Rainer, South Central District

JOHN A. HAWKINSON, MD, Easton, Eastern District

ALLEN J. O'NEILL, MD, Member at Large

WILFRED T. TUMBUSCH, MD, Hagerstown, Western District

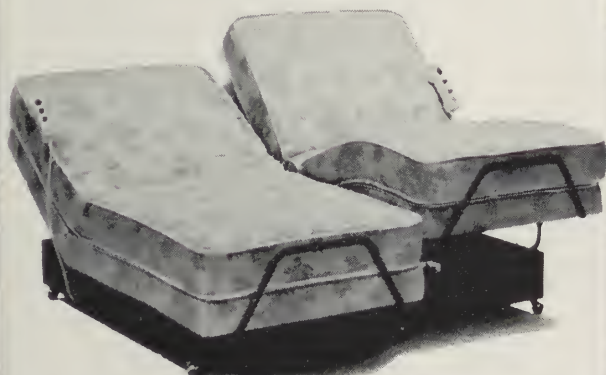
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BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

Your Bylaws Committee met on March 9, 1979, and recommends the following Bylaws amendments:

1. (a) Amend Article IV (Officers), Section 3, by striking out "15 days" and inserting "30 days."

(b) Amend Article IV (Officers), Section 6, by adding the following sentence: "Councilors in each newly elected annual class shall assume their duties at the close of the Annual Session, immediately preceding which they were elected."

Old

Section 3. One-third of the COUNCILORS shall be elected annually by the component societies from among their active and 40-year members who have had some previous active service at the component or Faculty level. Each component society shall be represented by one Councilor for the first 200 active or 40-year members or less and one additional Councilor for each additional 200 active or 40-year members or fraction thereof as determined annually on Dec. 31. Component Societies which are to elect Councilors shall do so by majority vote in a membership election. The results of the election shall be reported to the Faculty at least (15) days before the Faculty's annual session.

New

Section 3. One-third of the COUNCILORS shall be elected annually by the component societies from among their active and 40-year members who have had some previous active service at the component or Faculty level. Each component society shall be represented by one Councilor for the first 200 active or 40-year members or less and one additional Councilor for each additional 200 active or 40-year members or fraction thereof as determined annually on Dec. 31. Component Societies which are to elect Councilors shall do so by majority vote in a membership election. The results of the election shall be reported to the Faculty at least 30 days before the Faculty's annual session.

Section 6. ELECTIVE OFFICERS EXCEPT COUNCILORS shall hold office for a term of one year or until their successors are elected. Councilors shall hold office for a term of three years or until their successors are elected, provided that they may not serve more than two consecutive terms. Elective officers, except councilors, shall assume their duties at the close of the annual session one year after their election, except that the President-Elect shall assume that office at the close of the annual session at which he is elected.

Section 6. ELECTIVE OFFICERS EXCEPT COUNCILORS shall hold office for a term of one year or until their successors are elected. Councilors shall hold office for a term of three years or until their successors are elected, provided that they may not serve more than two consecutive terms. Elective officers, except councilors, shall assume their duties at the close of the annual session one year after their election, except that the President-Elect shall assume that office at the close of the annual session at which he is elected. COUNCILORS IN EACH NEWLY ELECTED ANNUAL CLASS SHALL ASSUME THEIR DUTIES AT THE CLOSE OF THE ANNUAL SESSION, IMMEDIATELY PRECEDING WHICH THEY WERE ELECTED.

The above change would clarify time when Councilors, elected by Component Medical Societies, would take office, and extend the period prior to the annual meeting by which such councilors' names are filed with the Faculty office.

2. Amend Article XI (Committees), Section 6, by substituting for it the following: "Section 6—A Medical Economics Committee of at least five members shall be appointed annually. It shall constantly review existing membership benefits other than insurance plans, making an annual report to the House of Delegates together with any recommendations it may have. It shall investigate new member benefit programs (except for member insurance benefits), determine their acceptability to the members and proceed with implementation of the programs approved by the Faculty's governing bodies. Once such a program has been

implemented, it shall be turned over to the committee of the Faculty charged with this responsibility or to the Med-Chi Services Agency, Inc., for operational purposes. Its Chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President."

Old

(All deleted)

Section 6. A MEDICAL ECONOMICS COMMITTEE of at least five members shall serve as a Review Committee for health insurance and other third party payors to determine equitable and just fees for procedures performed and for which such carriers are responsible. It may only act on the request of the carrier or patient or physician involved, and after the medical service has been rendered. It shall not determine the legal rights or benefits under such policies. It shall also be empowered to investigate, within the responsibilities and charges designated in these bylaws, areas of economic benefits for members of the Faculty. It shall receive the report of the Faculty's officially approved Professional Liability Program and shall prepare and present an educational program to physicians in this regard. Its Chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the President. The Maryland State Dental Association shall have the right to elect one associate member of the Committee with voice but no vote.

This change would broaden the responsibilities and change them so they conform to the current and potential areas of concern for Faculty members.

3. Amend Article XI (Committees), by substituting for Section 16 the following: "Section 16—A Legislative Committee shall consist of at least five members appointed by the President, one of whom the President shall designate as Chairman, together with one member of each component society and state-wide specialty society chosen by those societies annually. The Maryland State Dental Association shall have the right to choose one associate member of the committee with voice, but without vote. The committee shall inform itself on all legislation, national, state and local, affecting the practice of medicine; advise the Faculty when necessary in regard to such legislation and with the President or such other person as the Council or House of Delegates may name, represent the Faculty before any legislative body when required."

Old

Section 16. A LEGISLATIVE COMMITTEE composed of at least five members appointed by the President shall inform itself on all legislation, national, state and local, affecting the practice of medicine; advise the

New

Section 6. A MEDICAL ECONOMICS COMMITTEE OF AT LEAST FIVE MEMBERS SHALL BE APPOINTED ANNUALLY. IT SHALL CONSTANTLY REVIEW EXISTING MEMBERSHIP BENEFITS OTHER THAN INSURANCE PLANS, MAKING AN ANNUAL REPORT TO THE HOUSE OF DELEGATES TOGETHER WITH ANY RECOMMENDATIONS IT MAY HAVE. IT SHALL INVESTIGATE NEW MEMBER BENEFIT PROGRAMS (EXCEPT FOR MEMBER INSURANCE BENEFITS), DETERMINE THEIR ACCEPTABILITY TO THE MEMBERS AND PROCEED WITH IMPLEMENTATION OF THE PROGRAMS APPROVED BY THE FACULTY'S GOVERNING BODIES. ONCE SUCH A PROGRAM HAS BEEN IMPLEMENTED, IT SHALL BE TURNED OVER TO THE COMMITTEE OF THE FACULTY CHARGED WITH THIS RESPONSIBILITY OR TO THE MED-CHI SERVICES AGENCY, INC., FOR OPERATIONAL PURPOSES. ITS CHAIRMAN SHALL BE APPOINTED BY THE PRESIDENT AND SAID CHAIRMAN SHALL APPOINT THE OTHER MEMBERS OF THE COMMITTEE WITH THE APPROVAL OF THE PRESIDENT.

Section 16. A LEGISLATIVE COMMITTEE SHALL CONSIST OF AT LEAST FIVE MEMBERS APPOINTED BY THE PRESIDENT, ONE OF WHOM THE PRESIDENT SHALL DESIGNATE AS

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Faculty when necessary in regard to such legislation; and, with the President or such other person as the Council or House of Delegates may name, represent the Faculty before any legislative body when required. The President shall designate the chairman. The Maryland State Dental Association shall have the right to elect one associate member of the committee with voice but without vote. The President shall request each component society annually to appoint a representative to meet with the committee on a consulting basis at the request of the Chairman of the committee.

CHAIRMAN, TOGETHER WITH ONE MEMBER OF EACH COMPONENT SOCIETY AND STATE-WIDE SPECIALTY SOCIETY CHOSEN BY THOSE SOCIETIES ANNUALLY. THE MARYLAND STATE DENTAL ASSOCIATION SHALL HAVE THE RIGHT TO CHOOSE ONE ASSOCIATE MEMBER OF THE COMMITTEE WITH VOICE BUT WITHOUT VOTE. THE COMMITTEE SHALL INFORM ITSELF ON ALL LEGISLATION, NATIONAL, STATE AND LOCAL, AFFECTING THE PRACTICE OF MEDICINE; ADVISE THE FACULTY WHEN NECESSARY IN REGARD TO SUCH LEGISLATION; AND WITH THE PRESIDENT OR SUCH OTHER PERSON AS THE COUNCIL OR HOUSE OF DELEGATES MAY NAME, REPRESENT THE FACULTY BEFORE ANY LEGISLATIVE BODY WHEN REQUIRED.

The above changes will provide for full voting rights of Component Society and Specialty Society members selected by these groups to represent them on the Legislative Committee and also provide official representation on the same committee of Specialty Societies, who will also have full rights in this group.

The Bylaws Committee referred several items to the Policy and Planning Committee for its consideration and report to the appropriate body. These are:

Possible formation of a new committee on Membership

Possible formation of a new committee on Private Practice

Possible change in the bylaws that would permit individual physicians to determine the component society through which they would obtain membership in the Faculty. Present bylaws require the physician to live or practice in the area in which he holds membership. The Baltimore City Medical Society has suggested this option be given to each potential member, regardless of where he lives or practices, although restricting that right to "... the local medical society in which they have a major interest."

In addition, the Bylaws Committee determined that no change should be made in the bylaws that adopts the AMA Principles of Medical Ethics as the Faculty's guidelines, inasmuch as the AMA is engaged in substantial revision of these principles. The Bylaws Committee also considered the question of Emeritus Members continuing to serve on committees and have all the rights and privileges of Active members, except the right to vote and hold office in local components. It determined no change should be made in this provision at this time.

A request from the Montgomery County Medical Society was also considered. This dealt with a reduced rate of dues for Associate members who are serving as house staff at hospitals. Inasmuch as the current bylaws permit House Officers to be either Associate or Active members of the Faculty, the Bylaws Committee felt it not necessary to recommend any change in the dues for such individuals. Associate membership carries with it a lower dues structure than Active members.

This concludes the report of the Bylaws Committee to the House.

JOHN G. BALL, JR., MD, Chairman, Montgomery County

EDWARD W. DITTO, III, MD, Washington County

CHARLES F. O'DONNELL, MD, Baltimore County

WILLIAM R. ROUT, MD, Baltimore City

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

The Board of Medical Examiners is composed of the following members whose terms expire on the dates indicated below:

J. Roy Guyther, MD, President 1979

Karl F. Mech, MD,
Vice President 1980

Arthur T. Keefe, Jr., MD,
Secretary 1982

John E. Adams, MD 1981

Aris T. Allen, MD 1980

DeWitt E. DeLawter, MD 1981

Chris Papadopoulos, MD 1979

Daniel I. Welliver, MD 1981

Following are performance statistics:

FLEX Examinations:

Applications received 1098

Examinations given (includes
three Day III only) 1041

Failed 471

Passed and Licensed 570

National Boards' endorsement 545

Reciprocity of other States' Licenses 287

Free Licenses 1

Total 1978 Licenses 1403

Certifications to other states 391

Duplicate licenses issued 12

Renewal of Registration 9337

Physicians' Assistants 1978

Registrations 92

Cardiac Rescue Technicians 1978

Registrations 147

Professional Associations 1978

Authorized 15

The statistics above reflect the ever-increasing workload of the Board of Medical Examiners. Undisclosed by the statistics is the new administrative load imposed by the CME requirements for re-registration which became effective in September, 1978. Approximately 30 physicians have not been able to reregister their licenses because of the CME requirements. Many more have been given limited waivers for CME requirements after individual consideration by the Board.

In November, 1978, the long-awaited Advertising regulations were completed and promulgated. At present, they are awaiting final approval from the Attorney General's office.

The regulations for Physicians' Assistants have been revised to clearly define degrees of supervision both in private offices and institutional settings. The regulations for Mental Health Counselors have been completed by the Board and submitted for promulgation.

The Board has completed Acupuncture regulations which are being reviewed by the Attorney General's office before promulgation.



"SURE, YOU CAN GET YOUR HUSBAND TO DIET. JUST HAVE HIM READ THE GROCERY AD PRICES BEFORE DINNER."

A great deal of time has been spent on preparing the regulations which will govern the practice of medicine by Nurse Anesthetists, Nurse Midwives and Nurse Practitioners. By statute, these regulations must be written jointly by the Board of Medical Examiners and the Board of Examiners of Nurses. Various specialty groups, including the appropriate Committees of the Medical and Chirurgical Faculty, have been included in these long drawn-out discussions. An agreement has been reached on the regulations for Nurse Anesthetists; however, the regulations for Nurse Practitioners and Nurse Midwives are still under discussion because of the serious differences of opinion between the two Boards on the degree of supervision which will be required. The Board of Medical Examiners, while recognizing the

AMA-ERF REPORT (June 1, 1978 - May 31, 1979)

COUNTY	FACULTY	AUXILIARY	TOTAL
ALLEGANY	\$ 510	\$ 3,260.72	\$ 3,770.72
ANNE ARUNDEL	965	4,370.45	5,335.45
BALTIMORE CITY	4,675	471.00	5,146.00
BALTIMORE COUNTY	2,085	932.52	3,017.52
CECIL	230	50.00	280.00
CHARLES	150	253.00	403.00
HARFORD	470	3,941.86	4,411.86
HOWARD	420	1,045.00	1,465.00
MONTGOMERY	3,260	3,643.32	6,903.32
PRINCE GEORGE'S	1,975	2,011.27	3,986.27
TALBOT	300	1,407.70	1,707.70
WASHINGTON	470	1,844.18	2,314.18
WICOMICO	650	370.57	1,020.57

MEMBERS-AT-LARGE

CALVERT	50		
CAROLINE	10		
CARROLL	270		
DORCHESTER	120		
FREDERICK	310		
GARRETT	30	18.80	1,073.80
KENT	70		
QUEEN ANNE	—		
ST. MARY'S	110		
SOMERSET	20		
WORCESTER	55		
AFFILIATES	10		

STATE

		4,360.12	
TOTALS	\$17,215	\$27,080.51	\$45,195.51

* * * * *

AMA-ERF STUDENT LOAN FUND (Statistics for 1978)*

MARYLAND	103 Loans	\$148,600.00
STUDENTS	77	
INTERN AND RESIDENTS	26	
UNIVERSITY OF MARYLAND	51	
JOHNS HOPKINS	26	

MRS. ELMER G. LINHARDT
State Chairman, AMA-ERF



expanding roles of many new groups of health professionals, strongly maintains that the actual medical activities of these individuals be supervised by the medical profession. Continuing disagreement on this issue has delayed the completion of these regulations.

Staffing problems have continued to plague the Board despite the acquisition of an administrative assistant, Mrs. Hilda Stevan, who is doing much to increase the efficiency of the office; however, budgetary restrictions, under-staffing and, more recently, severe problems with the mail room make the Board less efficient and responsive than it should be.

Legislatively, the Board appreciates the veto of HB-741 by Governor Harry Hughes. This bill called for the designation of medical specialists by the Board of Medical Examiners in conjunction with Med-Chi. While recognizing the public interest and need for such designation, the Board felt that the bill in its present form raised more problems than it solved and would be impossible to implement.

The Board is watching with interest HB-425 which calls for "Special Funding" for the Board. This bill would greatly improve the function of the Board by removing the present arbitrary budgetary restrictions imposed upon it. This bill is being studied in Summer Session by the Legislature.

Three of the members of the Board of Medical Examiners continue to serve on the overworked and underfunded Com-

mission on Medical Discipline.

In conclusion, the Board would like to again emphasize the importance we attach to close liaison with Med-Chi. Every effort will be made by the Board to maintain these lines of communication.

Respectfully submitted,

ARTHUR T. KEEFE, JR., MD,
Secretary

HEALTH MANPOWER

Mr. President and Members of the House of Delegates:

The Committee on Health Manpower was established to monitor the distribution of physicians in Maryland through the collection and analysis of all available data on physician manpower and public needs.

During this past year, this Committee has directed its activities toward two related areas of concern: the apparent maldistribution of physicians and the lack of an adequate and reliable data base on which to develop appropriate recommended actions to improve availability and accessibility of primary care physicians.

The Committee looked critically at the relationship between the availability of physicians and the socioeconomic characteristics of Maryland Counties and Health service areas. This analysis revealed a distinct relationship of physician distribution to the socioeconomic status of the patient population. Specific population

characteristics examined were availability third-party coverage, availability of specialized medical services and the social and cultural makeup of urban, suburban and rural areas of the state.

Numerous methods of improving the distribution of and accessibility to physician services were discussed, and a number of possible incentives were suggested to induce physicians to practice where they are needed. Among suggestions were:

1) Ways to improve third-party coverage for low-income families, particularly for primary care visits to physician offices in underserved areas;

2) Pursuing direct subsidies for new physicians agreeing to practice in underserved areas and also

3) Assuring that some students who enter medical school will return to practice in underserved areas and remain there after any period of obligatory service.

Regarding the need for manpower data, the Committee was directed by Council to consider a request from the Baltimore City Medical Society for financial support to conduct a study of primary care delivery by physicians in Baltimore. The study was proposed because of inadequacies in available data on the provision of primary medical care services in the private office setting. The Committee determined, after a review of all possible sources of such data, that this study would provide a more complete and more valid determination of health planning goals,



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objectives and health plan implementation policies as they relate to the delivery of primary care. The final analysis of this data would be toward providing the medical and health planning communities with information as to how to improve existing primary care services, to develop additional analytical methodologies in physician manpower planning and to specify the present role of private practitioners involved in primary care delivery; however, because of the problems inherent in the study protocol as presented and the possibility of setting a precedent for similar requests from other component societies, the Council declined the Committee's recommendation that the Faculty participate by funding a portion of this study.

The Committee remains interested in the development of an improved manpower data base, and will be monitoring the progress of the Baltimore City Medical Society's efforts. Should the methodology being used to collect this data prove to be valid and reliable, the Committee may recommend that the Council consider replicating this study on a statewide basis at some future date.

In addition, the Committee offers its services to all component societies to assist in developing appropriate survey methodologies and analyzing manpower data made available through their efforts.

In addition to the activities mentioned above, the Faculty Health Planner assisted this Committee in responding to the health manpower segments of the draft Health Systems Plans for Maryland. Comments were forwarded to the local Health Systems Agencies addressing areas of concern to the physician community regarding the goals and objectives affecting health manpower and the delivery of health care services.

The Health Manpower Committee will continue to address these and other issues in the area of physician distribution and delivery of medical care. The Chairman wishes to take this opportunity to express his appreciation to each Committee member for services to the Faculty.

Respectfully submitted,

OSCAR C. STINE, MD, Chairman
TIMOTHY BAKER, MD
ARCHIE S. GOLDEN, MD
EDWARD KOWALEWSKI, MD

FREDERICK P. POKRASS, MD
FREDERICK J. RAMSAY, PhD
GERALD J. SCHIPPER, MD
AJAIB S. SIDHU, MD
RICHARD HOLZ, MD

GENERAL MEETING MAY 3, 1979 HUNT VALLEY INN, HUNT VALLEY, MD

A General Meeting of the Faculty was called to order as indicated above by the President, Francis C. Mayle, Jr., MD, at 4 PM. About 28 persons were in attendance, plus various staff members.

A motion was made to abolish the General Meeting required by House of Delegates' action at both the Annual and Semiannual sessions, because of the lack of attendance of the membership.

After much discussion and several amendments were withdrawn after presentation, the motion was overwhelmingly defeated.

It was agreed, however, that more publicity should be given to this General Meeting, both through the *President's Letter* and the *Executive Director's Newsletter*, and through other mechanisms including the notices sent to component societies, delegates, alternates, etc.

There being no further business, the President declared the meeting adjourned at 4:30 PM.

BERNARD S. KARPERS, JR., MD
Secretary

MEMBERSHIP

No report.



"IT IS CONTAGIOUS. SEVERAL OF MY PATIENTS HAVE GOT THE SYMPTOMS FROM THAT SOAP OPERA"

PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The Carousel in Ocean City was the 1979 Semiannual Meeting, a welcome return for our members who have enjoyed this location for many years. Total registration was 535, of which 387 were physicians. A varied scientific program was offered, and was well-attended despite the lure of the beautiful September weather. A limited number of technical exhibit spaces were sold to exhibitors who had products or services directly related to the scientific program. The social functions were well-attended. The MMPAC Luncheon was held within the week of the Gubernatorial Primary Election, and both the Democratic candidate, Mr. Hughes, and the Republican candidate, Mr. Beall, felt it propitious to accept an invitation to speak. All available luncheon tickets were sold, and there was standing room only around the perimeter of the luncheon area. The dinner/dance drew a sell-out crowd, and the traditional crab feast at Phillips Crab House,



EMIDIO A. BIANCO, MD
Program Committee Chairman, 1979-80
(Photo by Tadder, Balto.)

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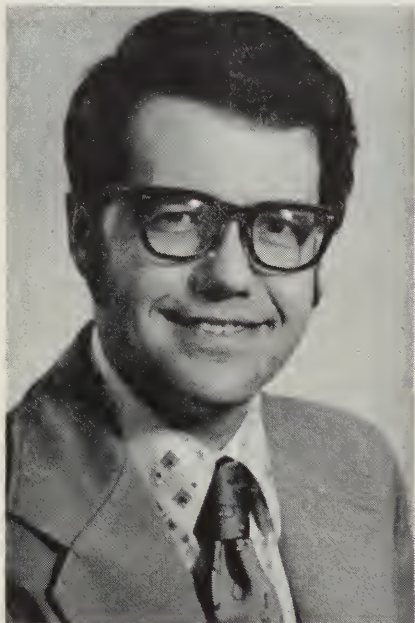
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HERBERT J. LEVICKAS, MD
PROGRAM COMMITTEE CHAIRMAN,
1980-81
 (Photo by Tadder, Balto.)

while drawing a small crowd, was an enjoyable afternoon.

The most varied scientific program ever offered, 39 different category I scientific sessions, made up the 1979 Annual Meeting at Marriott's Hunt Valley Inn. For the first time, the programming was extended to Friday afternoon, giving a full two-and-one-half days of scientific sessions. This enabled us to offer 18 hours of Category I Continuing Medical Education credit for the meeting. While there were few "standing room only" sessions, most were well-attended. Competition was keen for attendance in the six con-



ALVA S. BAKER, MD
Program Committee
 (Photo by Tadder, Balto.)

current sessions that were being held daily. *Recent Advances in Medicine and Their Application to Daily Practice*, the theme of the 1979 Annual Meeting, lent itself very well to the first plenary session to be held in recent years. The plenary session dealt with Prospective Medicine, a fairly-recent concept in medicine using health hazard appraisal. The Committee on Program and Arrangements feels the plenary session format is a good one, in that it gets most of the attendees together at one general session and gives a cohesiveness to the meeting. An innovation this year was the *Meet the Speaker* luncheon on Friday, which gave attendees an opportunity to meet on an informal basis with certain speakers from the Friday morning scientific sessions. This function was a sell-out, and was felt to be worth considering again in the future.

The MMPAC Luncheon, Prayer Breakfast and Lunch and Learn Session were well-attended, and the Health Evaluation Tests continue to be utilized by many Maryland physicians as their annual screening physical.

The Auxiliary sponsored a square dance on Thursday evening, and while the crowd was not large, those in attendance reportedly had a wonderful evening, full of fun.

The Presidential Banquet was held on Friday evening, and was a gala event enjoyed by all. The Head Table ceremonies were short and to the point, and there was lots of time for dancing and visiting with friends.

Total Annual Meeting attendance was 1,943, of which 1,092 were physicians.

Exhibit space at Hunt Valley Inn continues to be a problem, and the lack of space represents a loss of income to the Annual Meeting budget. At the time of the meeting, 37 technical exhibitors were on the waiting list, and could not be accommodated.

A move to the new Baltimore Convention Center, which is to be completed in the summer of 1979, will alleviate this problem. A serious problem in downtown Baltimore is the absence of suitable hotel rooms, and the Executive Committee has voted to not take the Annual Meeting to the Convention Center until the hotel rooms are available. This could possibly not come about until 1982.

Exhibit awards were given in both the scientific exhibit and technical exhibit classifications. There were many excellent exhibits, making it difficult for the Committee to select the three best in each category.

The Royal Sonesta Hotel, in New Orleans, LA is the site for the 1979 Semi-annual Meeting. Preparations are underway to obtain speakers from New Orleans for the scientific program. An interesting social program is being planned which includes Breakfast at Brennan's.

The 1980 Annual Meeting has been scheduled for Marriott's Hunt Valley Inn, and September, 1980 will find us in Williamsburg, VA for the Semiannual Meeting.

The Committee on Program and Arrangements very much appreciates all the help given to make this a successful meeting and wishes to thank the many individuals who gave so willingly of their time and effort. Among these are the Auxiliary, the Med-Chi staff, Dr. Richard Graham and all those volunteer physicians and technologists who worked to make the Health Evaluation Tests a success.

Respectfully submitted,

EDWARD F. COTTER, MD, Chairman
 Committee on Program and Arrangements

EMIDIO A. BIANCO, MD
HERBERT J. LEVICKAS, MD
ALVA S. BAKER, MD

MRS. THOMAS F. HERBERT,
 President, Auxiliary
 Subcommittee on Exhibits

HERBERT J. LEVICKAS, MD, Chairman

MR. LOUIS J. AIELLO, Bristol Labs
 Subcommittee on Health Evaluation Tests

RICHARD R. GRAHAM, MD, Chairman
JOHN DIACONIS, MD

MS. MARY JANE THOMMEN
PHILIP J. WHELAN, MD

MS. DOROTHY HARTEL
MORTON MOWER, MD

MS. JOYCE HUDSON
ABDOLHAMID GHILADI, MD
RONALD C. RICHTER, MD

AD HOC COMMITTEE ON NEW FACULTY BUILDING

Mr. President and Members of the House of Delegates:

The renovation of the gym located to the rear of former School #49, which is to the south of our present building, is complete and the facility is almost 100% occupied by various groups. In accordance with instructions from the House of Delegates, the Committee is in the process of having an evaluation prepared of the land in Howard County owned by the Faculty. When this is received, this property will be placed for sale.

Dedication ceremonies took place on Feb. 6, 1979 with Baltimore Mayor William Donald Schaefer present. Since then, Baltimore Heritage has awarded the Faculty a certificate honoring it for its excellent job of restoration.

It is hoped by the Annual Meeting of 1980, progress will be underway in connection with renovations of former School #49.

RUSSELL S. FISHER, MD,
 Chairman

Doctors Take Note:

Oct. 11-14, Soc. of Gastrointestinal Radiologists—Sci. Session and Postgrad. Course. Williamsburg Conf. Ctr. fee \$250. Contact: Martin W. Donner, MD, Dept. of Rad., Johns Hopkins Hosp. Balto., MD. 21205. Cat. 1-21 hrs.

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Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100. Liquid in bottles of 1 pint and 1 gallon.

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Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitroazanaphthal reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

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MARYLAND STATE MEDICAL JOURNAL

*Mr. President and Members of the House
of Delegates:*

This report covers the period August, 1978-August, 1979, a period marked by continued growth in the stature of the *Journal*. In April, 1979, the *Journal* received an Honorable Mention in the Sandoz Pharmaceutical Medical Journalism Competition. The award was for excellence in design and editorial content. The Managing Editor deserves the credit for this award.

The *Journal's* 1978-79 monthly mailing schedule was maintained on time, and there were no operational problems with our printing firm, Boyertown Publishing Co. of Boyertown, PA, with which we continue to enjoy an excellent working relationship.

Local advertising remains excellent as a result of the continuing highly-effective ad sales campaign presented by the Shirley Arnowitz Advertising Agency. In addition, the *Journal* continues to receive a good share of the national advertising market in the State Medical Journal Bureau.

The combination of increased advertising revenue, plus a concerted effort on the part of the staff to decrease the costs of production, resulted in a savings to the *Faculty* of almost \$20,000. The savings occurred without a concomitant decrease in the quality of the *Journal*.

The *Journal* continues to receive an increasing number of scientific and other scholarly manuscripts on topics of practical value to practicing physicians throughout the state. Plans for the future include more feature articles dealing with the activities of Maryland physicians. Active solicitation of manuscripts of interest to practitioners in diverse specialties in all areas of the state will continue.

The Editorial Board is more active than ever and the full Board meets quarterly. During the year, Chinmoy Banerjee, MD joined the Board for a three-year term. The Editor and Associate Editor appreciate the interest and dedication of the Editorial Board in working toward an even better product.

As always, all comments regarding all facets of the *Journal* are thoroughly considered and are always welcome. The basis for any editorial decision will always be gladly shared with any member of Med-Chi.

Respectfully submitted,

JIM ZIMMERLY, MD, JD, MPH,
Editor

Editorial Board

RICHARD CIOFFI, MD

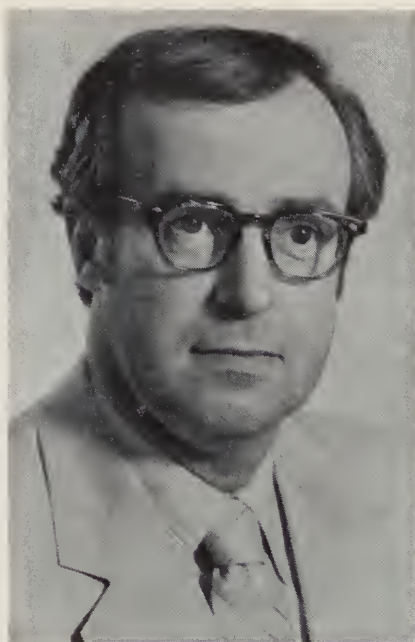
JAMES P. G. FLYNN, MD, MPH

RAYMOND J. DONOVAN, JR., MD

ELIZABETH B. SHERRILL, MD

FRANK LYNN IBER, MD

CHINMOY BANERJEE, MD □



JAMES G. ZIMMERLY, MD, JD, MPH
Editor of the *Journal*.

(Photo by Tadder, Balto.)

COUNCIL

A total of nine Executive Committee and seven Council sessions were held during the past year. As has been the custom for some time, these meetings are summarized in the *Maryland State Medical Journal*. In addition, copies of the Minutes are mailed to all Component Societies, as well as Council members. It is hoped through this method all members are aware of the activities that guide the affairs of the Faculty.

Some of the major items of business discussed and on which action was taken are as follows:

1. Instituted legal action against the Health Services Cost Review Commission in connection with proposed regulations controlling physicians' fees. The regulations were withdrawn by the HSCRC.

2. Authorized publication of advertisements in selected weekly newspapers in Maryland, these ads being copies of those published on a national basis by the AMA. The Faculty's name was utilized in the advertisements.

3. Adopted a policy with respect to second opinions, which has been published and made available to all members.

4. Adopted a position that the Faculty Members' health insurance program should include broader benefits for psychiatric care, as well as for alcoholism treatment.

5. Suggested names to the Governor's office in connection with possible appointment to the Health Services Cost Review Commission. Roland T. Smoot, MD, of Baltimore, was named to one of the vacancies in this group.

6. Adopted a position in connection with proposed regulations dealing with Nurse/Midwives Nurse/Anesthetists and Nurse/Practitioners, and extended legal action, if necessary, to resolve the dif-

ferences in the Faculty position and that of the Nursing groups.

7. Discussed at some length whether or not legal action should be taken in connection with funding of the Board of Medical Examiners activities and the Commission on Medical Discipline activities. Pending possible legislative action, withheld taking any action in this connection.

8. Learned of and approved participation in an Inter-Agency Task Force which is looking into the potential of reviewing in-hospital patient care to ensure quality medicine is provided and to afford a mechanism to interested governmental agencies for review of questioned matters in this area.

9. Learned that the Federal Election Commission had issued a subpoena for certain Faculty records in connection with MMPAC activities. Nothing further has been heard in this regard.

10. Approved addition of a full-time employee to become involved in health planning activities and to coordinate and keep local societies apprised of local HSA determinations and decisions; as well as state activities in this area.

11. Authorized a wage and salary study to be conducted by an outside consultant.

12. Approved investigation of a retirement and pre-retirement program for members through the Physician Rehabilitation Committee.

13. Approved inviting the AMA to hold its Fourth National Impaired Physician Conference in 1980 in Baltimore.

14. Approved cooperation in promotion of TelMed, a telephone answering service that plays for inquirers information on specific diseases or conditions.

15. Approved cooperation with the Auxiliary in connection with a potential plan for Family Relations.

16. Approved a proposed fundraising program for library endowments.

These highlights, while summarised in a brief manner, did receive considerable thought and study by committees and Council members prior to their adoption. An expression of appreciation is given to all Council members who attended faithfully the Council sessions and participated fully in its activities. It was a pleasure to serve as Council Chairman and I hereby express my appreciation to the entire membership for permitting me to serve in this capacity.

VINCENT J. FIOCCO, MD,
Chairman □

Doctors Take Note:

The Union Memorial Hospital, Baltimore:

Sept. 17-18, Postgrad. Course for the Use of the Surgl. Stapler in Oncology, Tuition—\$250. Faculty: Clifford R. Wheelless, Jr., MD, Wm. H.B. Howard, MD. Approved for 16 cred. hrs. in AMA Cate. I.

Sept. 20-21, The 4th Annual John M. Haws Postgrad. Sem. in OB/GYN: "Contemporary Trends in Gyn and OB Practice," Tuition—\$175.

For details, call Dr. Wheelless at (301) 235-5255.

MEDICINE AND RELIGION

Mr. President and Members of the House of Delegates:

According to its Bylaws, the Medicine and Religion Committee shall concern itself with maintaining effective liaison and lines of communication between physicians and clergymen in order to provide the most effective care and treatment to the patient and his family. Throughout the year, the Committee has directed its efforts toward fulfilling this responsibility.

Action of the Committee for the past year is as follows:

1. Discussion took place with respect to the establishment of voluntary Life Preservation Advisory Groups in hospitals throughout Maryland. It is the belief of this Committee that such groups provide an invaluable service to those individuals who are daily faced with the dilemma of making life and death decisions. This is actively being pursued at present.

2. Reverend Clyde Shallenberger, Director of Chaplaincy Services for Johns Hopkins Hospital, delivered the formal presentation during the Prayer Breakfast which took place during the Annual Meeting. His presentation proved to be thoroughly enjoyable and contributed greatly to the overall success of the meeting.

The Committee also sponsored one of the Lunch and Learn Sessions. Dr. Jack M. Zimmerman and Father Paul S. Dawson, both of whom are associated with Church Hospital, were invited to moderate a session on their highly-successful research activities on hospices.

3. It was noted that many of the colleges, medical schools and seminaries may not be aware of the existence of the Committee. It was agreed to send a letter to these organizations informing them that the Committee is available and most

willing to offer assistance and guidance in areas of mutual concern.

4. Several Committee members remain deeply concerned over the increasing number of physicians refusing to treat medical assistance patients. The "ACCESS" program currently being conducted by the Allegany County Medical Society has been rather successful in this area. The Committee felt this program should be given further study, and, quite possibly, used as a model program for the entire state. Following further discussion, this may be referred to the Liaison Committee for consideration by that group.

The Chairman would like to thank all members of the Committee for their invaluable assistance and support throughout the year.

Respectfully submitted,

LESLIE R. MILES, JR., MD, Chairman
EDWIN H. T. BESSON, MD
H. RONALD FRIEDMAN, MD
MAURICE B. FURLONG, JR., MD
J. ALEX HALLER, JR., MD
WILLIAM L. MATZKIN, MD
SALLY T. MEJIA, MD
GEORGE C. MERRILL, MD
JIN H. RHEE, MD
J. COURTLAND ROBINSON, MD
MARTIN SINGEWALD, MD
WILLIAM SPENCER-STRONG, MD
GIBSON J. WELLS, MD
OLEG ZIMMERMAN, MD
Advisory Members
IRA MORRIS, MD
REV. CLYDE SHALLENBERGER □

SECRETARY

Mr. President and Members of the House of Delegates:

It is the responsibility of the Secretary to ensure that Faculty is operating in an efficient manner, that Committees are properly staffed, that policies established

by the Faculty are communicated, that records, letters and all other activity emanating from the Faculty office are current and are handled in a prompt and efficacious manner. It is my pleasure to report that this occurs.

Meeting notices are mailed well in advance of meetings and, again, are handled in an effective manner. All meetings are attended by a staff person. Minutes of all meetings are promptly written so they can be reviewed by Committee Chairmen and distributed to Committee members.

In addition to outgoing mail, several hundred pieces of mail arrive each day in the Faculty office and are routed to the appropriate staff persons for disposition. Many responses are mailed each day and the volume of this mail continues to increase. Also, the office of the Secretary corresponds with component medical societies, communicating the Faculty business in both directions, to and from the components.

Of interest is the continued increase of membership in component medical societies and the Faculty. At the beginning of the 1979-80 Faculty year, we have a total of 5,556 members, broken down into 4,764 Active and 40-Year, 189 Emeritus, 176 Associate and 421 Affiliate.

It is a secure feeling to know the Faculty staff is courteous, efficient and effective in carrying out assigned responsibilities. The enthusiasm of the staff is appreciated and their devotion to duty is duly noted. The well-deserved thanks of all officers and members go to these faithful employees who perform their work without concern for time, effort or their own personal needs.

BERNARD S. KARPERS, MD,
Secretary □

HOME HEALTH CARE

Mr. President and Members of the House of Delegates:

The Ad Hoc Committee on Home Health Care held one meeting this year to review Medicare directives relative to Vitamin B12 administration, and to review a draft proposal regarding Home Health Care for inclusion into the Annual Plan developed by the Maryland Health Planning and Development Agency. The Ad Hoc Committee is confident that its attention into these matters has resulted in policies assuring quality for home health care patients.

The Chairman wishes to express his appreciation to the members of the Committee for devoting their attention to these issues as they arise.

Respectfully submitted,

J. D. DRINKARD, MD
Chairman
G. EDWARD REAHL, MD
FRANK SHIPLEY, MD
CHARLES O'DONNELL, MD
RAYMOND DONOVAN, MD
WILLIAM LAW, MD
J. EMMETT QUEEN, MD □



ENJOYING THE FACULTY SQUARE DANCE are (left to right) DR. and MRS. PAUL SNOW; DR. and MRS. LESLIE R. MILES (partially-hidden); MRS. HERBERT LEIGHTON; MRS. CHARLES HOWELL; DR. HERBERT LEIGHTON and EDMUND NIKLEWSKI, MD.
(Photo by Joseph E. Jensen, Faculty Librarian.)

POLICY AND PLANNING

Mr. President and Members of the House of Delegates:

Throughout the past year, the Policy and Planning Committee has held regular meetings to consider ways in which to improve services by the Faculty to component societies and to consider long-range policies and goals of the Faculty.

Several items were discussed during the past year. As a result of data obtained to carry out a national survey of State Medical Societies and Blue Shield Plans, a Resolution was introduced calling for Blue Shield of Maryland to 1) Abolish the profile system of determining physician payment; 2) abolish the "service" concept under Blue Shield policies and; 3) adopt a policy of accepting assignment of payments to physicians in the same manner as do commercial health insurers. The Council did not adopt the resolution, but this issue will remain a continuing agenda item for consideration by the Committee.

In another area of activity, the Committee developed a proposal to establish a periodic or graduated dues increase which would accomplish the objective of a balanced budget, meet the needs of the membership, as well as establishing a set sum of contingencies and reserves which would be built up to at least one year's estimated operating budget. The proposed system takes into consideration our inflationary economy and provides for fair and thorough input into the budget by all Delegates, Alternate Delegates and Component Society Officers. This is to be considered at a future meeting of the Council.

The Committee is also considering a proposal for the development of a credit union for the benefit of Faculty members. A Subcommittee has recommended this concept. The membership will be surveyed through the annual 20% survey in the near future. The Committee has also endorsed a Membership Recruitment Proposal designed to approach prospective members through personal physician contact.

The Committee also considered a proposal from the Baltimore City Medical Society to revise Faculty Bylaws to allow physicians to join the local society in which they have their major practice.

Existing Bylaws require membership based on either where the physician maintains his principal office or that component area wherein he lives. Based on changing practice locations, and on possible effects on existing peer review mechanisms, the Committee recommended that the bylaws be changed so that after initial appointment and membership acceptance, a physician may elect to retain his membership in the component society through which is elected, even though he may move his practice and home outside of that component's area.

Judging from the many socioeconomic issues facing organized medicine, there appears to be a great need for this Committee. Component Societies are urged to ensure the presence of their representatives so that we may adequately answer this need. The Committee is confident that the actions taken this past year have that the actions taken this past year have to equally-productive meetings in the year ahead.

Respectfully submitted,

JOHN R. DAVIS, MD, Chairman
CALVIN Y. HADIDIAN, MD
THOMAS CULLIS, MD
JOHN B. DeHOFF, MD
MARTIN E. STROBEL, MD
RICHARD H. FISHER, MD
HENRY A. TRAPNELL, MD
ALVA S. BAKER, MD
ERNEST SEITER, MD
TIRSO E. JASON, MD
DONALD R. McWILLIAMS, MD
WAYNE ALLGAIER, MD
THOMAS G. JOHNSON, MD
FREDERICK J. HATEM, MD
FREDERICK BERGMANN, MD
ROBERT W. FARR, MD
OCTAVIO POLANCO, MD
LEON LEVITSKY, MD
JOHN R. SMITH, MD
WILLIAM C. MULFORD, MD
JAMES A. STERLING, MD
P. GREGG RHODES, MD
FRANK BRUMBACK, MD
ANDREW J. FORGASH, MD
THOMAS L. JONES, MD



Doctors Take Note:

The Second Annual Ophthalmology Conference For The Non-Ophthalmologist Physician: The Eye and Systemic Diseases, will be held on Saturday, Oct. 13, 1979, in the Cafetorium of The Fairfax Hospital, 3300 Gallows Rd., Falls Church, VA 22046, (703) 698-3785. This program is approved for six credit hours in Category I by the AMA and is acceptable for six Prescribed hours by the AAFP.

HEARING AND VISION EARLY SCREENING (HAVES)

Mr. President and Members of the House of Delegates:

Screening to identify three-year-old children for vision and/or hearing problems was conducted in 80 preschools and/or 28 community sessions located in Baltimore City, Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Talbot and Washington Counties during the past year.

Public service announcements of the programs by the press, radio, TV, posters and fliers indicated the joint sponsorship of the Medical and Chirurgical Faculty, the Maryland Society for the Prevention of Blindness and the local service clubs.

Reports to parents of the 4,114 children who were tested advised them to consult their children's physician or usual source of medical care regarding the screening performance.

Orientation, health education and training sessions were held, as needed, for the service organizations who conduct the program under the supervision of the Maryland Society for the Prevention of Blindness.

The Community screening sessions held by a new group, the Bayside Jaycettes, in the Calvert County Hospital, have been enthusiastically received.

The Ladies Auxiliary to the Four County Medical Society deserves special recognition for its effort over the past six years. They annually check approximately 267 children enrolled in eight Talbot County preschools and Head Start centers.

Respectfully submitted,

GEORGE C. ALDERMAN, MD, President
Board of Directors
CYRUS L. BLANCHARD, MD
RICHARD E. HOOVER, MD
FRANK P. DWYER, JR., MD
ANTHONY F. HAMMOND, MD
MRS. JANE D. ELLEN
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LIBRARY AND HISTORY FINNEY FUND

Mr. President and Members of the House of Delegates:

The past year can be characterized as a period of rapid growth in the use of the Library's services by members of the Medical and Chirurgical Faculty. This growth is reflected both in an increase in the number of member physicians who actively use the Faculty Library and in an increase in the volume of services provided to them.

The number of Faculty members who made use of the Library's services at least once during the 1978-79 year increased 38.4% over the 1977-78 year. In terms of specific Library services, the number who used the computerized bibliographic services (especially MEDLINE) increased 54.9%, those who requested photocopies increased 21.9% and the number of members for whom the Library borrowed materials from the National Library of Medicine, medical school libraries and other sources increased 39.3%.

The Library is used by members of every one of the Faculty's component societies. The fact that its services are available through the mail and by telephone assures that physicians in the remote and rural sections of Maryland have the same access to biomedical information services as the physicians located close to large metropolitan medical libraries. The following chart compares the geographic distribution of Faculty members who used the Library's services in 1978-79 with the geographical distribution of the Faculty's total membership for the same period:

Geographic Area	% of Library Services Received by Med-Chi Members in the area	% of Total Med-Chi members in the area
Baltimore City	38.8%	32.9%
The Five Counties in the Baltimore Metropolitan Area	31.7%	24.1%
Prince George's and Montgomery Counties	12.7%	28.3%
Southern Counties on Western Shore	2.3%	1.7%
Western Maryland Counties	7.6%	6.8%
Eastern Shore Counties	6.9%	6.2%

Computerized bibliographies, photocopied journal articles and interlibrary loans represent the three major library services available to Faculty members. Use of all these services by the membership increased substantially during the 1978-79 year. The number of bibliographies provided increased 27.2% over 1977-78; the number of photocopied journal articles provided increased 38.7% and the number of items borrowed from other libraries increased 104.9%.

The following table illustrates this

growth in the volume of the Library's major services over the past year, and it also shows the figures for telephone reference calls, books circulated to Faculty members and items loaned to other libraries:

Library Services	1977-78	1978-79
Computerized bibliographies (MEDLINE, etc.)	1,205	1,533
Photocopied journal articles	4,158	5,768
Items borrowed from other libraries	1,131	2,317
Books circulated to Faculty members	580	576
Items loaned to other libraries	2,328	983
Telephone reference questions	8,230	9,072

The fact that the number of books circulated to Faculty members has remained constant, while the number of journal articles provided, and the number of items obtained from other libraries (usually journal articles) have increased, is significant. Circulation of books used to be the Library's major function. The advent of computerized bibliographic searching has increased Faculty members' awareness of current information in periodical literature, and it is now demanded much more than the dated information found in monographs. This trend will influence the Committees and the Librarian in the allocation of the Library's endowed income in the coming year.

The decrease in the number of materials loaned to other libraries is largely the result of improved hospital libraries throughout Maryland and an increased

several factors, most of which were itemized in the 1977-78 annual report as means to increase awareness among Med-Chi members of the Library benefits that accompany their memberships. During the past year, the Librarian attended and

spoke at seven component society meetings. In addition, a member of the Library staff attended each meeting of the Baltimore City Medical Society with an exhibit of current books and a bibliographic handout related to the topic of the meeting. The Library Committee's Chairman addressed the annual meeting of the officers of the component and specialty societies.

A new brochure describing the Library and its services was directed toward the general membership. A copy was mailed to every existing member, and one will be sent to each new member and each newly-licensed physician in the state.

As much as one-fourth of the Library's services to Faculty members are distributed through hospital libraries, since many physicians find it convenient to have their hospital librarians request materials and bibliographies for them. The development of strong core libraries in hospitals results in better library services to Faculty members. The important items that are likely to be urgently-needed are close at hand, allowing the Faculty Library to concentrate its collection on materials that hospital libraries would not be expected to own. During the past year, the Librarian conducted a basic course on *The Organization, Management*



and Services of a Small Hospital Library in Havre de Grace and Easton, and a course on *Basic Reference Tools and Techniques* in Easton, Cumberland, Baltimore and Frederick. In addition, he made consultation visits to eight hospitals throughout the state. In most cases, the purpose of such a visit is to establish a program that will bring the hospital's library up to the standards required for JCAH accreditation. This leads to improved library services available to Faculty members in the area and increased use of the Faculty Library.

The following table reflects the growth of the Library's resources during the 1978-79 year:

Library Resources		
	1977-78	1978-79
Books added	841	840
Journals bound	713	317
Total volumes added		1,157
Previous total volumes		103,909
Current total volumes		105,066

The drop in the number of volumes bound is due to a lull in binding of almost one year that occurred in 1976-77. The effort to catch up in 1977-78 resulted in a distorted figure for that year.

Current estimates show the cost of medical books increasing at 9% per year, and medical periodical costs are rising at about the same rate. This figure exceeds the annual increases in income to the endowed funds that support the Library's book and journal purchases.

During the coming year, the Library Committee and the Finney Fund Committee will take a very careful look at the Library's book selection policy and journal subscriptions. It is likely that purchases of monographs will be limited to those items required to support the reference services and to those recommended or requested by Faculty members. The current periodical subscriptions will be compared with a list of the titles most frequently requested and a list of the titles that must frequently be borrowed from other libraries. As a result, unused titles will be dropped and others that are in demand by members will be added.

In addition, the Library Committee has begun efforts to increase endowment support for the library. Two leaflets are ready for publication and distribution. The first, about the William Osler Associates, encourages members and the component and specialty societies to endow individual periodical subscriptions. The second leaflet, *Your Will Can Help*, informs members how to include the Faculty Library in their wills.

The Carroll Fund, initiated in 1978 to honor the late Douglas G. Carroll, Jr., MD, a former Chairman of the Library Committee, raised a principal of \$13,000. The income to this fund will be used to

purchase materials related to Maryland's medical history and to pulmonary medicine, which were Dr. Carroll's chief interests.

The Librarian, Assistant Librarian and the Cataloging and Acquisitions Specialist represented the Faculty Library at the Medical Library Association's annual meeting in Chicago in June; all attended continuing education courses. The Librarian spoke to new library school graduates on job prospects in medical society libraries. In addition, he was elected Chairman of the Medical Society Libraries Special Interest Group of the Medical Library Association, and he serves on the Association's Bibliographic and

was elected to a two-year term on the Regional Advisory Council. During the last year, the Librarian completed a five-year term as Chairman of the Region's Online Services Committee, and he is now a member of the Region's Education Committee.

Library Staff, as of April, 1979:	
Joseph E. Jensen, Librarian	
Adam Szczepaniak, Jr., Assistant Librarian	
Patricia Munoz, Cataloging and Acquisitions Specialist	
Frances Yatsevitch, Reference and Circulation Librarian	
Eleanor Mason, Secretary to the Librarian	
Patricia Poleski, Reference and Circulation Assistant	
Ronald Rothermel, Serials Assistant	


A primary goal for the coming year is the previously-mentioned assessment of the Library's collection policies, in view of the information needs of the Faculty's membership. Coupled with this will be the drives to increase the Library's endowed income to meet both rising costs and the increased demand for services by the membership. Additional goals include a thorough weeding of outdated and unimportant materials from the collection to allow room for growth, persistent efforts to increase awareness of the Library and its benefits among Faculty members, continuing attempts to upgrade hospital libraries and the preparation of an appropriate celebration and memorial for the 150th anniversary of the Faculty Library in June, 1980.

Respectfully submitted,
Library and History Committee
MARCO CLAYTON, MD, Chairman
KATHERINE A. CHAPMAN, MD
PAUL F. GUERIN, MD
MARGARET L. SHERRARD, MD
ROLAND T. SMOOT, MD

Information Services Assessment Committee.

The Librarian, Assistant Librarian, Cataloging and Acquisitions Specialist and the Reference and Circulation Librarian represented the Faculty Library at the meeting of the Mid-Atlantic Regional Group of the Medical Library Association in Annapolis, MD, in October, 1978. The Librarian served on the Program Committee for the meeting and chaired the Local Arrangements Committee. All the Library staff contributed to making this a successful session.

The Librarian represents the Faculty Library on the Regional Advisory Council of the Mid-Atlantic Region of the National Library of Medicine's Regional Medical Library Program. Also, the Faculty's Executive Director, John Sargeant,



THE ARTICLE ACUTE MOUNTAIN SICKNESS—concerning some mountaineering ailments—was featured as the cover story of the March, 1979 issue of the *Journal*.

(Photograph by Faculty Librarian Joseph E. Jensen, himself a mountaineer.)

H. BERTON McCAULEY, DDS
Finney Fund Committee
D.C.W. FINNEY, MD, Chairman
RICHARD V. HAUVER, MD
JAMES P. McCARRICK, MD
GEORGE W. SETTLE, MD
PETER V. THORPE, MD

AUXILIARY

Mr. President and Members of the House of Delegates:

Dr. Mayle, Dr. Pillsbury, Dr. Fiocco and members of the House of Delegates. I thank you for opportunity to appear before you and give the annual report of our State Auxiliary. It is vibrant, successful and growing.

Last July, in St. Louis at the National Convention of the AMA Auxiliary, our President, Mrs. Chester L. Young of Kansas, gave this quote in her farewell speech: "He has achieved success who has lived well, laughed often and loved much; who has gained the respect of intelligent men and the love of small children." She ended there, but I would continue with the next line, that is: "Who has filled his niche and accomplished his task, who left the world better than he found it."

This quote describes the members of the Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. Our membership numbers almost 950 State and over 81,000 National members. All of our members are volunteers, an almost extinct group of people. We volunteer our time to promote an honorable profession, medicine, and we gladly volunteer many hours of service to Community Health Projects.

This year, our component Auxiliaries sponsored, taught or manned CPR classes, Blood Pressure Clinics, Hearing and Vision Screening, aided the State Immunization Program by providing posters, hop-sotch stencils, a film entitled, *Don't Let the Bug Bite You*, a one-minute spot announcement for TV and one county taped a radio appeal on Immunization. Other components sat as advisors local School Boards, pushed for Health Educa-

tion Programs in schools and sent drugs, medical journals and surgical supplies to Appalachia, South America and India. We have worked with other organizations, such as the PTAs and the Maryland Teachers Associations and have sent a representative to the National Safety Council's Regional Meeting. It's been a busy year, we had fun along the way and we made friends.

I want to thank Dr. Mayle for the consideration, courtesy and support he provided during the entire year. To members of the Council, thank you for inviting the President of the Auxiliary to attend your meetings. It is through these encounters that your Auxiliary learns of medicines' concerns and involvement with the community.

To members of the Program and Arrangements, Public Relations and Legislative Committees, Mr. Sargeant and the you for your unfailing assistance and Med-Chi staff, I personally want to thank sharing of your expertise.

It was a privilege to pay tribute to

FINANCE

Mr. President and Members of the House of Delegates:

The year 1978 was marked by volatility, both in the economy and the stock market. For the year as a whole, real growth in the economy was about 4% and prices rose approximately 7.5%. The growth was achieved in spurts with disappointing numbers in the first and third quarters, and ebullient expansion in the second and fourth. Inflation was high throughout the year, except for a brief summer respite.

Stock prices were similarly erratic. A decline in the first quarter was followed by a strong rally which lasted until October, when many of the gains were lost. The year finished on a positive note, and the growth stocks did better than the market averages. Unfortunately, rising interest rates caused most bonds to decline in value, and this trend is likely to continue in 1979.

T. Rowe Price anticipates a slowdown



MRS. THOMAS HERBERT, OUTGOING AUXILIARY PRESIDENT, addresses the House of Delegates at Hunt Valley Inn, Annual Meeting, May, 1979.

(Photo by Joseph Jensen, Faculty Librarian.)



the men and women of Medicine this year by working in your Auxiliary. Thank you.

MRS. KASSIE HERBERT
 President

AUXILIANS MRS. ALBERT J. STRAUSS, JR. (Left) Auxiliary President and MRS. DANIEL HOWELL, President of the Charles County Auxiliary, receiving an award.
 (Photo by D. Bruce Van Alstine.)

in 1979 and possibly a recession. It is hoped that the downturn will be mild and not a repeat of the severe recession of 1974. Because of the high degree of uncertainty in the economy, our advisors are rather tentative about investment strategy.



ROBERT B. GOLDSTEIN, MD
Faculty Treasurer

Our Chairman, Dr. "Mac" Boyer, died in 1978. This Committee will miss his valued counsel and sincere friendship. He served his fellow physicians in many ways.

ROBERT B. GOLDSTEIN, MD
THEODORE OSIUS, MD
ARTHUR T. KEEFE, MD
E. W. DITTO, JR., MD

□

TREASURER

Mr. President and Members of the House of Delegates:

The financial books and records of the Medical and Chirurgical Faculty have been audited for the year 1978. The audited financial reports reflecting the results of the operations of the year, and

the financial position of the Faculty at year-end 1978 are part of the report. The auditors have submitted an unqualified opinion that our financial statements are accurate and conform to generally-accepted accounting principles. The Faculty's financial position remains sound after the year of operating within the established budget.

The budget for 1979 was approved by the Council. It reflects a deficit of income to expenditures, which will be funded by accumulated reserves. The Faculty will need to begin planning for a change in dues structure.

The report of the Finance Committee will include a review of the Faculty investment portfolio.

ROBERT B. GOLDSTEIN, MD,
Treasurer □



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Financial
Reports
appear in
the **Journal**
each August.

ANNUAL FINANCIAL STATEMENTS MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

WOODEN & BENSON

Certified Public Accountants

Members American Institute of Certified Public Accountants

100 West Pennsylvania Avenue

Baltimore, Maryland 21204

301-825-4860

The Medical and Chirurgical Faculty
of The State of Maryland
Baltimore, Maryland

We have examined the balance sheet of The Medical and Chirurgical Faculty of The State of Maryland as of December 31, 1978 and December 31, 1977 and the related statements of income, expenditures and transfers and changes in fund balances for the years then ended. Our examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of The Medical and Chirurgical Faculty of The State of Maryland as of December 31, 1978 and December 31, 1977 and the income, expenditures and transfers and changes in fund balances for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Apr. 19, 1979

/s/ WOODEN & BENSON □

1979 ESTIMATED INCOME
(Adopted by Council, Jan. 25, 1979)

	1978 BUDGET	PROJECTED THROUGH DEC. 1978	1979 BUDGET
MEMBERSHIP DUES	686,000.00	701,012.50	700,000.00
INVESTMENT INCOME			
Restricted Fund Earnings	8,000.00	15,000.00	15,000.00
Short Term Interest	40,000.00	50,000.00	50,000.00
MEDICAL JOURNAL	70,000.00	77,541.22	55,000.00
ANNUAL and SEMIANNUAL MEETINGS	35,000.00	43,922.75	40,000.00
OTHER INCOME	12,500.00	13,896.00	12,500.00
TOTAL	<u>851,500.00</u>	<u>901,372.47</u>	<u>872,500.00</u>

PROPOSED BUDGET
1979 ESTIMATED EXPENDITURES

	BUDGET 1978	PROJECTED ACTUAL THRU DECEMBER	BUDGET 1979
Auditing	5,000.00	4,500.00	5,000.00
Legal	20,000.00	18,668.13	20,000.00
Contributions	1,000.00	-0-	1,000.00 *A
Fuel	6,000.00	5,714.26	6,000.00
Gas, Electricity, Water	9,000.00	10,674.44	12,000.00
Telephone and Telegraph	14,000.00	13,797.16	15,000.00
Postage	20,000.00	19,473.13	20,000.00
Household and Janitorial	2,500.00	2,721.67	3,000.00
Property Maintenance	6,000.00	4,445.78	6,000.00
Insurance	5,000.00	5,090.66	6,000.00
Special Equipment Services	5,000.00	3,840.56	5,000.00
New Equipment	5,000.00	525.67	5,000.00
Equipment Maintenance	2,000.00	1,730.17	2,000.00
Stationery and Supplies	5,000.00	6,524.18	7,000.00
Salaries	391,000.00	389,358.83	455,771.00
Social Security	20,000.00	19,302.09	25,000.00
Unemployment Compensation	6,000.00	8,000.00	8,000.00
Employees' Insurance Program	14,000.00	17,538.48	20,000.00
Employees' Pension	55,000.00	53,836.08	55,000.00
Supplementary Hours	3,500.00	2,784.09	3,500.00
Travel	26,000.00	25,646.89	30,000.00 *B
Printing	15,000.00	12,448.23	15,000.00 *C
Data Processing-Membership Records	10,000.00	13,726.84	12,000.00
Governmental Relations	15,000.00	13,818.81	15,000.00 *D
Library	13,000.00	13,326.00	16,525.00 *E
Journal Expense	95,000.00	110,652.62	85,000.00
Annual and Semiannual Meetings	65,000.00	70,131.27	70,000.00
Presidential Fund	1,000.00	563.24	1,000.00
Auxiliary	1,000.00	1,000.00	1,000.00
Miscellaneous Expenses	7,500.00	7,777.16	10,000.00
TOTAL	<u>843,500.00</u>	<u>857,616.44</u>	<u>935,796.00</u>

* See Explanatory Notes

Coming in the Journal:

**Second Conference on the
Canadian Health Care System**
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Maryland Advertisers:

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Doctors Take Note:

Sept. 10-11, **NIH Consensus Development Conference on intraocular lens implantation**, Bethesda, MD sponsored by Natl. Eye Inst., Natl. Insts. of Health. For details call (301) 496-4905.

1979 BUDGET NOTES

A. CONTRIBUTIONS:

Reflects a reserve for possible requests during the year.
Budgeted items include:

American Student Medical Association	
University of Maryland Chapter	\$300.00
Johns Hopkins Chapter	300.00
Miscellaneous	400.00
	<u>\$1,000.00</u>

B. TRAVEL:

Includes attendance at following meetings:

Professional Convention Management Association, Jan. 6-14, San Francisco, Calif., (one staff member).

Regional Legislative Conference, Ft. Lauderdale, Florida, Jan. 4-6, one staff member.

National Medical Leadership Conference, Chicago, President, President-elect, Council Chairman, two staff members, Feb. 15-18.

Chief Executive Officers State Medical Association, Hilton Head, South Carolina, March 11-13.

Attendance at Regional AAMSE Seminars, 4-5 staff members, location not known.

Regional AMA Meeting, three Delegates, three alternate Delegates, President, President-elect, C.E.O. Wash., DC, Apr. 24-25.

AMA Annual Session, Chicago, July 22-26, three Delegates, three alternate Delegates, President, President-Elect, two staff members.

Medical Society Executive Conference, in conjunction with above, three staff members.

AMA Interim Session, Hawaii, Dec. 2-5, three Delegates, three alternate Delegates, President, President-Elect, two staff members.

Medical Society Executive Conference, in conjunction with above, two staff members.

American Society of Association Executives, Annual Meeting or similar education activity, St. Louis, MO, Aug. 4-8, two staff members.

Executive Conference, ASAE, date and place to be announced, one staff member.

Travel throughout the state for various component society meetings, other business and activities, as well as out of state Regional and National Sessions as determined on an individual basis.

C. PRINTING:

Includes the publication cost of the membership directory.

D. GOVERNMENTAL RELATIONS:

Includes nurses' salaries and supplies for First Aid Room, telephone hot line, publications printing and mailing costs and travel.

E. LIBRARY:

Includes Memberships, Travel, Supplies, Equipment, Photocopying, Postage and Miscellaneous Library expenditures. Library salaries are in the salary account. **Journal** subscriptions, books, binding, etc., are purchased by designated funds and are not included in this item.

Exhibit B-1

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND Baltimore, MD

STATEMENT OF INCOME, EXPENDITURES AND TRANSFERS GENERAL FUND

	For Years Ended	
	Dec. 31, 1978	Dec. 31, 1977
Income		
Dues	701,265	687,125
Rents and services	3,826	4,375
Meetings	43,923	36,088
Journal advertising and subscriptions	80,211	65,328
Interest	62,329	51,871
Miscellaneous	35,035	13,217
	<u>926,589</u>	<u>858,014</u>
Expenditures		
Operating expenses	844,000	784,573
Excess of income over expenditures	<u>82,589</u>	<u>73,441</u>
Transfers		
From consolidated Fund income	2,422	2,423
From special funds	12,124	11,665
	<u>14,546</u>	<u>14,088</u>
Excess of income and transfers over expenditures	<u>97,135</u>	<u>87,529</u> <input type="checkbox"/>

The accompanying notes to financial statements
are an integral part of this statement.

Be Informed!

Don't miss a single **RADIOLOGICAL CASE OF THE MONTH.**
Read the **JOURNAL!**

ELECTION OF THE BOARD OF MEDICAL EXAMINERS GENERAL MEETING MAY 3, 1979

A general meeting of the Medical and Chirurgical Faculty of the State of Maryland was held on May 3, 1979, at Noon for the purpose of electing members of the Board of Medical Examiners. The session was held at the Hunt Valley Inn, Hunt Valley, MD.

Francis C. Mayle, Jr., MD, President, presided and called the meeting to order at 12:02 PM.

The names of the following nominees were presented to the general meeting as follows, both for a four-year term, commencing in June, 1979:

Manning W. Alden, MD, Annapolis, MD
Chris Papadopoulos, MD, Baltimore, MD

Nominations from the floor were requested. There being none, the President declared nominations to be closed and the Secretary was instructed to cast one ballot for those nominated. They were declared elected at 12:05 PM, and the general session called for this purpose was adjourned at the same time.

BERNARD S. KARPERS, MD
Secretary ☐

Doctors Take Note:

Sept. 6th, Should We Begin a Hospice Program? A Workshop for Hospital Planners and Decision-Makers, Internatl. Hotel, Baltimore-Washington Internatl. Airport. Conducted by MD Hosp. Educ. Inst. For details, call (301) 321-6200.

**STATEMENT OF INCOME, EXPENDITURES AND TRANSFERS
CONSOLIDATED FUND—INCOME ACCOUNT**

	For Years Ended	
	Dec. 31, 1978	Dec. 31, 1977
Income		
Distributive share of investment income	16,692	16,810
Less - investment advisor fees	3,118	3,232
Net distributive share of investment income	13,574	13,578
Direct share of investment Income	1,280	1,068
	<u>14,854</u>	<u>14,646</u>
Expenditures		
Library and lectureship	21,237	9,618
Other	3,500	2,000
	<u>24,737</u>	<u>11,618</u>
Excess (deficiency) of income over expenditures	(9,883)	3,028
Transfers to General Fund	2,422	2,423
Excess (deficiency) of income over expenditures and transfers	<u>(12,305)</u>	<u>605</u> <input type="checkbox"/>
The accompanying notes to financial statements are an integral part of this statement.		

Exhibit B-3

**STATEMENT OF INCOME, EXPENDITURES AND TRANSFERS
MED-CHI INSURANCE TRUST**

	For Years Ended	
	Dec. 31, 1978	Dec. 31, 1977
Income		
Administrative fees	41,107	21,322
Interest	31,193	26,923
	<u>72,300</u>	<u>48,245</u>
Expenditures		
Administrative services	8,715	10,901
Insurance	116	765
Postage, printing and supplies	206	2,062
Rent	725	725
Telephone	240	240
Professional fees	1,500	4,250
Miscellaneous	126	—
	<u>11,628</u>	<u>18,943</u>
Excess of income over expenditures	<u>60,672</u>	<u>29,302</u> <input type="checkbox"/>
The accompanying notes to financial statements are an integral part of this statement.		

**MARYLAND FOUNDATION
FOR HEALTH CARE**

*Mr. President and Members of the House
of Delegates:*

During the past year, the Foundation has completed its study on malpractice incidence in Maryland, which was carried out under a grant from the US Department of HEW. In addition, the Foundation acts as Fiscal Agent for the Renal Dialysis program, Network #31, which currently rents space from the Faculty in its renovated facility facing on Maryland Avenue and to the rear of the present Faculty building at 1211 Cathedral St. in Baltimore.

The Foundation is also continuing to carry out its responsibility under subcontract from the AMA for improving medical care in local jails. This contract has been renewed through mid-1980. The Director also acts as a consultant to other similar programs under the auspices of State Medical Associations throughout this area of the country. Visits are made to train personnel in this type of activity, to assist in inspection of jails, and to generally advise on the operation of their programs.

Recognizing a need for a 501 (c) (3) corporation funds given to which can be taken as a tax-deduction by the contributor, the Foundation established the Maryland Institute for Public Health Research. Two meetings of the Board of this group have been held and exploration of potential projects is taking place. Currently, consideration is being given to a physician reeducation project which could be used to evaluate the present medical school curriculum as well as the value of continuing medical education courses.

The feasibility of other studies is also under consideration. The Institute will also become the sponsoring organization for Tel-Med, the concept of which has been approved by the Faculty Council. Current members of the Board of the Institute are: Edward J. Kowalewski, MD; Alvin D. Ankrum, B. Robert Fellerman, Irving J. Kessler, MD; Albert J. McGann, Edyth H. Schoenrich, MD; John W. Shaffer, PhD and George Tyler, Esq.

EDWARD J. KOWALEWSKI, MD,
Chairman ☐

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BALANCE SHEET

	ASSETS	General Fund	Endowment and Special Funds	Plant Fund	Med-Chi Insurance Trust	Total December 31, 1978	Total December 31, 1977
Current							
Cash		1,054,994	432,351	144	222,940	1,710,429	1,469,703
Accounts Receivable							
Membership dues, journal and advertising		22,596	—	—	—	22,596	27,659
Other funds		161,567	156,733	—	—	318,300	260,088
Other		50,884	—	—	—	50,884	12,271
Med-Chi Insurance Agency, Inc.		28,887	—	—	1,231	30,118	5,698
Loans receivable—Plant Fund		36,842	—	—	—	36,842	36,842
Prepaid expenses		4,853	—	—	—	4,853	254
		<u>1,360,623</u>	<u>589,084</u>	<u>144</u>	<u>224,171</u>	<u>2,174,022</u>	<u>1,812,515</u>
Marketable Securities		—	940,133	—	—	940,133	926,834
Investment—Med-Chi Insurance and Services Corporation		5,000	—	—	—	5,000	5,000
Fixed							
Land, buildings, and improvements		—	—	823,808	—	823,808	669,322
Other		—	—	373,720	—	373,720	373,720
		<u>—</u>	<u>—</u>	<u>1,197,528</u>	<u>—</u>	<u>1,197,528</u>	<u>1,043,042</u>
		<u>1,365,623</u>	<u>1,529,217</u>	<u>1,197,672</u>	<u>224,171</u>	<u>4,316,683</u>	<u>3,787,391</u>
LIABILITIES AND FUND BALANCES							
Current							
Accounts Payable							
Trade		3,311	—	—	82,520	85,831	9,779
Other funds		—	60,718	248,867	8,715	318,300	260,088
Component Societies		496,746	—	—	—	496,746	362,722
Payroll taxes		2,779	—	—	—	2,779	394
Grants payable		32,965	—	—	—	32,965	30,828
Deferred income		308,063	—	—	—	308,063	256,544
Loans payable—General Fund		—	—	36,842	—	36,842	36,842
		<u>843,864</u>	<u>60,718</u>	<u>285,709</u>	<u>91,235</u>	<u>1,281,526</u>	<u>957,197</u>
Fund Balances							
Designated							
Legal Fund		38,998	—	—	—	38,998	44,130
Educational purposes		66,759	—	—	—	66,759	61,069
Other		3,719	—	—	—	3,719	4,020
Undesignated		<u>412,283</u>	<u>1,468,499</u>	<u>911,963</u>	<u>132,936</u>	<u>2,925,681</u>	<u>2,720,975</u>
		<u>521,759</u>	<u>1,468,499</u>	<u>911,963</u>	<u>132,936</u>	<u>3,035,157</u>	<u>2,830,194</u>
		<u>1,365,623</u>	<u>1,529,217</u>	<u>1,197,672</u>	<u>224,171</u>	<u>4,316,683</u>	<u>3,787,391</u> □

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Mr. President and Members of the House of Delegates:

PAC was again very successful in its support of candidates in the 1978 elections. Five congressional candidates were supported in the Primary and General Elections, and our only loss was in the 8th Congressional District.

The luncheon meeting in Ocean City was very well-attended by members and the news media. The speakers were both candidates for Governor, only three days after the Primary Elections. MMPAC

was fortunate to be able to provide the forum for the first public meeting of the candidates.

Freshman Congressman Daniel B. Crane spoke at the MMPAC luncheon meeting on May 2, 1979. His address was entitled *From Womb to Tomb*. Maryland received its second AMPAC Leadership Recognition Award in June, 1978 in St. Louis. The award was accepted by the Vice Chairman, Mrs. Helen Boyer. We hope to again receive that award this year.

The membership for 1979 is already well above 1978. The increase of 653 brings the total membership to 2,523. The sustaining membership is also higher, but not near as much as it should be.

Again this year, we plan to have a PAC

seminar for the members who wish to become more active in politics and civic activities. It will probably be held in October, 1979 so as not to conflict with vacations, graduations and medical meetings.

We in the PAC solicit the help of each and every member of the House of Delegates and also Med-Chi to increase our membership, particularly the sustaining ones. The next two years before the 1980 elections will be filled with controversial issues, and we need to identify candidates who are more prone to listen to the problems of medicine.

Respectfully submitted,

RICHARD F. MOSCHELL, MD
Chairman □

SCHEDULE OF RECEIPTS, EXPENSES, AND FUND BALANCES
CONSOLIDATED FUND—INCOME ACCOUNT
FOR THE YEAR ENDED DEC. 31, 1978

Fund	Distributive Share (Percent)	Fund Balance Jan. 1, 1978	Investment Distributive Share - Net	Income Direct Share	Expenses Library and Lectureship	Other	Transfer To General Fund	Fund Balance Dec. 31, 1978
Baker	.65	42	88	—	—	—	—	130
Barker, Lewellyn F.	.39	3	53	—	—	—	—	56
Bowen, Joseph S.	9.17	—	1,245	—	—	—	1,245	—
Bressler, Frank C.	1.80	—	244	—	—	—	244	—
Cordell, Eugene Fauntleroy	3.64	34,848	494	1,280	—	3,500	—	33,122
Cowles, Nellie N.	.75	1,452	102	—	—	—	—	1,554
Finney, John M. T.	8.40	18	1,140	—	301	—	—	857
Frick, William F.	15.02	924	2,039	—	1,420	—	—	1,543
Friedenwald, Dr. Julius F.	.75	—	102	—	—	—	102	—
Harlan, Herbert	.76	255	103	—	—	—	—	358
McCleary, Standish	.75	—	102	—	178	—	—	(76)
Osler Endowment	1.40	—	190	—	—	—	—	190
Osler, Testimonial	7.75	5,530	1,052	—	—	—	526	6,056
Ruhrah, John	40.79	27,508	5,537	—	18,516	—	—	14,529
Stokes, William Royal	3.09	292	420	—	314	—	—	398
Trimble, John Ridgeway	2.64	2,752	358	—	508	—	—	2,602
Woods, Hiram	2.25	—	305	—	—	—	305	—
	<u>100.00</u>	<u>73,624</u>	<u>13,574</u>	<u>1,280</u>	<u>21,237</u>	<u>3,500</u>	<u>2,422</u>	<u>61,319</u>

Summary

Cash

Savings account 27,597

Cordell Fund

Cash 38,924

Investments 25,506

64,430

92,027

30,708

Accounts payable — other funds 61,319 □

Doctors in the News

Hopkins Urologist Receives Top Urology Award

William W. Scott, MD, Professor Emeritus of Urology at the Johns Hopkins School of Medicine, has been awarded the 1979 Keyes Medal, which is given periodically for outstanding contributions to the advancement of urology. The award is given by the American Association of Genito-Urinary Surgeons, founded by Edward L. Keyes, a prominent genito-urinary surgeon.

As Chairman of the Department of Urology at Hopkins from 1946-74, Dr. Scott established a basic

research program that developed an international reputation for such discoveries as how certain steroids inhibit androgen and how certain hormones make androgens more potent. Androgens are hormones involved in the development of male sex organs.

Dr. Scott, who also has a PhD in physiology, is well-known for his own research on the prostate gland and prostatic cancer. He introduced the use of anti-androgen for treatment of prostatic cancer and benign prostatic enlargement. Use of anti-androgen is being explored in experiments at several institutions around the country because it

apparently has fewer side-effects than the estrogen compounds now being used on patients.


In related work, Dr. Scott is examining patient histories to evaluate the effectiveness of chemotherapy on prostatic cancer and to see if it can be determined in advance which patients would respond to hormonal therapy. Evidence so far strongly suggests that such therapy is effective for men who have androgen receptors in the prostate.

Dr. Scott's interest in research led to his founding **Investigative Urology**, a prominent journal devoted to basic research. He has been Chairman of the National Prostatic Cancer Project's Subcommittee on Treatment and has won numerous awards, including the American Medical Association's Gold Medal.

**SCHEDULE OF FUND BALANCES
CONSOLIDATED FUND—PRINCIPAL ACCOUNT
FOR YEAR ENDED DEC. 31, 1977**

<u>Fund</u>	<u>Purpose</u>	<u>Fund Balance Jan. 1, 1978</u>	<u>Gain on Sale of Securities</u>	<u>Investment Income</u>	<u>Fund Balance Dec. 31, 1978</u>
Baker	Book of Materia Medica	3,201		33	3,234
Barker, Lewellyn F.	Library	1,921		19	1,940
Bowen, Joseph S.	General	45,117	4	462	45,583
Bressler, Frank C.	General	8,855	1	91	8,947
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	17,910	1	183	18,094
Cowles, Nellie N.	Books of Neurology	3,691	1	38	3,730
Finney, John M. T.	Books, Journals and Lectureships on Surgery	41,318	4	423	41,745
Frick, William F.	Maintenance of Frick Library and Purchase of Books and Journals	73,888	6	757	74,651
Friedenwald, Dr. Julius F.	Maintenance of Friedenwald Room	3,691	1	38	3,730
Harlan, Herbert	Books on Ophthalmology	3,743		38	3,781
McCleary, Standish	Lectureships and Books on Pathology	3,691	1	38	3,730
Osler Endowment	Permanent Endowment for Library by Request of Dr. Osler	6,883		71	6,954
Osler Testimonial	Medical Books and Maintenance of Osler Hall	38,123	3	391	38,517
Ruhrah, John	Library, Books, Journals, etc.	200,668	81	2,056	202,805
Stokes, William Royal	Lectureship and Books on Bacteriology or Pathology	15,208	1	156	15,365
Trimble, John Ridgeway	Lectureship Only	12,991	1	133	13,125
Woods, Hiram	General	11,078	1	113	11,192
		<u>491,977</u>	<u>106</u>	<u>5,040</u>	<u>497,123</u>


□



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MT. WILSON, MARYLAND 21112."**

NOTES TO FINANCIAL STATEMENTS DEC 31, 1978

Note 1—Summary of Significant Accounting Policies

The Medical and Chirurgical Faculty of The State of Maryland is a nonprofit organization, tax exempt under Section 501 of the Internal Revenue Code.

Marketable securities are carried at cost. Market values at Dec. 31, 1978 and 1977 were \$1,005,281 and \$921,888, respectively.

The Faculty carries its investment in the 100% owned Med-Chi Insurance and Services Corporation at cost. Income in the form of dividends will be recorded when received. The net assets of the corporation as of December 31, 1978 were as follow:

Current assets	140,982
Fixed assets—net	11,841
	<u>152,823</u>
Current liabilities	32,225
	<u>120,598</u>

Fixed assets, other than personal property, are recorded at cost. Portraits were appraised as of December 31, 1963 at \$65,000, an increase of \$51,000 over prior years. All other personal property was appraised as of Dec. 31, 1949. Depreciation on fixed assets is not provided. Current acquisitions are expensed. A schedule of fixed assets follows:

Real Estate	1978	1977
Unimproved land—Howard County	204,107	204,107
Land—1215-1217 Cathedral Street	19,119	19,119
1209-1215 Cathedral Street		
Land and building	110,636	110,636
Improvements	331,525	331,525
1205-1207 Cathedral Street and 1204 Maryland Avenue		
Land and buildings	25,361	—
Improvements	133,060	3,935
	<u>823,808</u>	<u>669,322</u>
Other	1978	1977
Library books, journals	231,370	231,370
Office and library—fixtures, antiques and museum pieces	77,350	77,350
Portraits—appraised value	65,000	65,000
	<u>373,720</u>	<u>373,720</u>
	<u>1,197,528</u>	<u>1,043,042</u>

Note 2—Pension Plan

The Faculty has a noncontributory pension plan covering substantially all its employees. Pension contributions for the current year and prior year were \$48,722 and \$37,325, respectively, which includes amortization of prior service cost over 20 years. The Faculty's policy is to fund pension costs accrued. At April 1, 1978, the pension fund's most recent valuation date, the fund's net assets exceeded the actuarially computed value of vested benefits by \$24,495. □



DR. UMHAU

ington University, he has two sons in medical school: one at Bowman Gray and one at the University of Maryland. A third son is in the pre-med program at Davidson College in North Carolina.

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Doctors in the News

Dr. Umhau Elected

John B. Umhau, Jr., MD of Chevy Chase, MD was elected President of the Maryland Academy of Family Physicians at their Annual Meeting in Bethesda recently.

Dr. Umhau, Past President of the Montgomery County Medical Society, has been a member of the

Med-Chi Council since 1975 and was until recently a member of the Planning Committee.

Currently the Chairman of the Medical Staff of Suburban Hospital in Bethesda, Dr. Umhau has practiced Family Medicine in Chevy Chase for 25 years.

A 1952 graduate of George Wash-

For the latest information on Med-Chi Annual and Semi-annual Meetings, read the Journal every month!

Doctors Take Note:

Sept. 28-30, Cardiac Symptoms, Arrhythmias and Holter Monitoring, Arlington Hyatt, Wash., DC. For details, call (800) 525-8646 toll free.

SCHEDULE OF OPERATING EXPENSES GENERAL FUND

	For Years Ended	
	Dec.	Dec.
	31, 1978	31, 1977
Accounting fee	4,500	4,000
Communications—		
postage, telephone, etc.	31,678	27,732
Equipment rental and maintenance	2,958	6,981
Fuel	4,214	4,431
Gas, electricity and water	10,674	7,793
Household and janitorial expense	2,722	2,234
Insurance—general	5,120	4,114
—employee benefits	14,775	15,498
Journal expense—		
printing and commissions	111,775	111,255
Legal fees	18,363	23,352
Legislative expenses	13,819	14,915
Library	13,291	9,270
Meetings—annual and semiannual	69,923	59,410
Data processing	13,727	8,415
Office supplies	6,478	4,313
Pension plan and		
major medical, etc.	53,171	43,127
Printing	12,407	8,583
Equipment purchase	526	9,367
Maintenance of property	4,446	6,079
Salaries	367,375	335,242
Deferred compensation expense	21,608	17,118
Social security tax	19,918	17,873
Supplementary hours	2,906	3,453
Travel	25,623	27,813
Unemployment insurance—		
Federal and State	7,707	5,328
Women's auxiliary	1,000	1,000
Miscellaneous	3,296	5,877
	<u>844,000</u>	<u>784,573</u> □

Medical Miscellany

Loyola College Fall R_xMBA Program Accepting Applications

Applications are now being accepted for the fall 1979 class of Loyola College's executive program in health care management (R_xMBA) in Baltimore. The graduate program, which began in fall of 1978, is geared to top executives in health care and related fields.

Similar to Loyola's executive master in business program, R_xMBA is a two-year master's degree program drawing students principally from the Baltimore, Columbia and Washington, DC areas. Classes convene on alternate Fridays and Saturdays throughout the academic year at Loyola's Columbia Center.

Currently, 30 men and women are enrolled in the first R_xMBA class which will complete the program in spring of 1980.

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LANDMARK DEVELOPMENT CORPORATION

South Light Street / Baltimore, Maryland 21202 (301) 752-6565

It could be your best move all day.

Doctors Take Note:

Sept. 27th, The Dept. of Surgery of St. Agnes Hospital Balto., is presenting a **Primary Care Symposium**. This one-day Symposium is for the Internist, General Practitioner and Family Practitioner, in the St. Agnes Nursing Auditorium. Some of the topics to be presented are the Office Management of Chronic Pain, the Detection of the Drug-Abusing Patient, Evaluation of Intra-Oral Lesions, and the Diag. of the Depressed Patient. This meeting is acceptable for five credit hours from the AMA and also from the AAFP. Registration fee is \$20 for the meeting and this includes a luncheon. For further info., call Dr. John A. Singer, (301) 368-6377.

in meeting nationwide pressures for a new type of generally-trained health executive, R_xMBA concentrates on training executives broadly and rigorously in analytical approaches to problem-solving and policy-planning. It prepares participants for a variety of organizational settings and addresses issues of personal, community and environmental health services through marketing, financial and planning systems already successfully implemented by business corporations.

Dr. Robert Austin Milch, Professor of Health Care Management in Loyola's Business Administration Department, directs the program. Dr. Milch holds degrees from Columbia University and from Loyola, and is former Professor of Orthopedic surgery at Johns Hopkins University School of Medicine. He served as special assistant in the White House Office of Science and Technology during the Johnson Administration and, most recently, was a principal in the management consulting department of the Washington, DC office of Peat, Marwick Mitchell and Co. □

CONTINUING MEDICAL EDUCATION

Mr. President and Members of the House of Delegates:

Six meetings of the CME Committee were held during the Faculty year of 1978-79, with action taken by the Committee in the following areas:

Since the initiation of the accreditation process, the following hospitals/organizations have been granted institutional accreditation following site surveys:

1. *American Cancer Society—Baltimore City Unit.
2. +American Heart Association—Baltimore.
3. +Ann Arundel General Hospital—Annapolis.
4. Bon Secours Hospital—Baltimore.
5. Calvert Memorial Hospital—Prince Frederick.
6. Chestnut Lodge—Rockville.
7. +Children's Hospital—Baltimore.
8. Church Hospital—Baltimore.
9. Community Psychiatric Clinic, Inc.—Wheaton.
10. *Crownsville Hospital Center—Crownsville.
11. *Department of Health and Mental Hygiene—Baltimore.
12. Doctors' Hospital of Prince George's County—Lanham.
13. Dorchester General Hospital—Cambridge.
14. Fallston General Hospital—Fallston.
15. Franklin Square Hospital—Baltimore.
16. Frederick Memorial Hospital—Frederick.
17. *Good Samaritan Hospital—Baltimore.
18. Greater Baltimore Medical Center—Towson.

19. Harford Memorial Hospital—Havre de Grace.
20. Holy Cross Hospital—Silver Spring.
21. Lutheran Hospital of Maryland—Baltimore.
22. Maryland General Hospital—Baltimore.
23. Maryland Hospital Education Institute—Lutherville.
24. Maryland Radiological Society—Baltimore.
25. *Maryland Psychiatric Society—Baltimore.
26. +Memorial Hospital—Easton.
27. *Memorial Hospital—Cumberland.
28. Mercy Hospital—Baltimore.
29. Montgomery General Hospital—Olney.
30. +Montgomery Village Seminars—Gaithersburg.
31. The Neurology Center—Chevy Chase.
32. North Arundel Hospital—Glen Burnie.
33. +North Charles General Hospital—Baltimore.
34. Peninsula General Hospital—Salisbury.
35. Post Graduate Institute—Cheverly.
36. Prince George's General Hospital—Cheverly.
37. Provident Hospital—Baltimore.
38. Sacred Heart Hospital—Cumberland.
39. St. Agnes Hospital—Baltimore.
40. +St. Joseph Hospital—Towson.
41. Sheppard and Enoch Pratt Hospital—Towson.
42. Sinai Hospital—Baltimore.
43. South Baltimore General Hospital—Baltimore.
44. Springfield Hospital Center—Sykesville.
45. +Spring Grove Hospital—Baltimore.

46. Suburban Hospital—Bethesda.
47. Taylor Manor Hospital—Ellicott City.
48. Union Memorial Hospital—Baltimore.
49. +Veterans Administration Hospital—Perry Point.
50. +Washington Adventist Hospital—Takoma Park.
51. Washington County Hospital—Hagerstown.

Survey pending for:

52. Kernans Hospital—Baltimore.

Accreditation pending for:

53. Greater Laurel Beltsville Hospital—Laurel.

NOTE: *—indicates accreditation granted during 1978-79.

+—indicates accreditation renewed during 1978-79.

Those hospitals/organizations having no marking were site surveyed and granted accreditation in previous years.

Other Action:

A. In response to a request, the Committee considered whether verifying physician attendance should be discontinued at the Annual and Semi-annual Meetings. The Committee concluded the present voluntary system is flexible and reasonable and would not support any effort to discontinue it.

B. The Bylaws of the Committee have been revised and updated to reflect the true scope of the Committee.

C. A policy statement was formulated limiting cosponsorship of CME activities to component and/or statewide specialty societies.

D. The Committee reviewed and accepted revised guidelines on the types and duration of accreditation issued by the Liaison Committee on Continuing Medical Education.

E. Negotiations with the LCCME led to the reversal of their decision to deny renewal of accreditation to a local institution. Provisional accreditation was ultimately granted.

F. The Committee continues to be deeply concerned over the numerous problems related to the accreditation process since the Liaison Committee on Continuing Medical Education assumed authority several years ago. The intolerable delays, and the fact that the state committees have not been kept well-informed by the LCCME, led the Committee to develop a resolution calling for the return of accrediting authority to the state organizations whose standards are in agreement with the American Medical Association and the LCCME. Further, that failing such an agreement, the Medical Faculty cease recognition of the LCCME as accrediting authority for CME in Maryland, and concern itself only with the CME needs of the physicians in Maryland as mandated by the Board of Medical Examiners. The resolution was



CME COMMITTEE CHAIRMAN C. EARL HILL, MD (center) shakes hands with Dr. Edward J. Kowaleski (right), Professor and Chairman of the Family Practice Program at the University of Maryland School of Medicine, at a recent function of the Maryland Academy of Family Practice, as Hans J. Koetter, MD (left) applauds.



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...in the functional bowel/irritable bowel syndrome*

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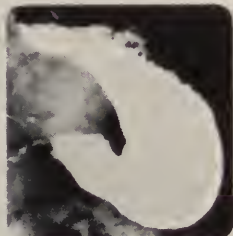
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helps control abnormal motor activity
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Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdose, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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adopted by Council, and has been forwarded to each state, district and territory with the recommendation that they consider and support similar action.

This has been a very busy and productive year for the Committee. The workload requires continuing organization and administrative assistance, in addition to maximum efficiency in the operation of the Committee. My thanks to each and every member of this Committee for their dedicated service and a job well-done.

Respectfully submitted.

C. EARL HILL, MD,
Chairman

IAN ANDERSON, MD

IRVIN H. COHEN, MD

WORTH B. DANIELS, JR., MD

CENAP S. DORKAN, MD

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HEALTH PLANNING

Mr. President and Members of the House of Delegates:

The Committee on Health Planning met several times during the past year to exercise its responsibility of monitoring the developments in health planning at the local, state, and national levels, and the legislative and bureaucratic changes in the laws, rules, and regulations pertaining to planning activities.

In order to facilitate our efforts in this regard, the Committee recommended and received approval to employ a full-time Health Planning Specialist to monitor the activities of the five local Health Systems Agencies and the State Health Planning and Development Agency. This staff person will establish working relationships with these groups, review drafts of the Annual Health Systems Plan and report on proposed regulations in terms of what effect they may have on the delivery of medical care. He will also work with

Faculty Committees and component societies on matters pertaining to health planning and related matters at all levels. With such professionally-trained staff, the Committee intends to strengthen its ability to monitor activities of the health planning bureaucracy and to influence its policies so that optimal levels of health care may be maintained.

The past year has seen the drafting of the second-year Health Systems Plan by the five Health Systems Agencies in Maryland. These plans were reviewed by the Faculty Planner, and found to represent credible attempts to identify the complexities which are affecting the development of a comprehensive health care delivery system; however, they lacked appropriate and reasonable goals and objectives, especially in the area of health manpower availability and accessibility. Letters were directed to all HSAs delineating the areas of concern to the physician community.

At the State level, the Committee has been closely following the drafting of the State Health Plan. The Executive Director of the State Health Planning and Development Agency met with the Committee to discuss the activities of the Statewide Health Coordinating Council, the State Health Plan, proposed legislation and possible regulations for establishment of Hospices for the terminally-ill.

The Committee has been monitoring the activities of the Appropriateness Review Task Forces which the State Health Planning and Development Agency has established in the areas of Cardiac Surgery/Catheterization, Obstetric/Newborn and Radiation Therapy services. The Task Forces are presently setting standards and criteria for institutional review in these areas. The Faculty's representatives on these Task Forces have been effective in ensuring that rational criteria and standards are developed for this mandated health planning activity.

In the area of legislation, the State Health Planning and Development Agency had proposed the extension of Certification of Need regulations to include private physician offices should capital expenditures for equipment exceed \$150,000. This legislation was defeated during the last legislative session, primarily by efforts of Faculty representatives.

The Chairman wishes to express his appreciation to the members of the Committee for donating their time to the matters of the Committee during the past year. The Committee is confident that the actions taken this year have been sound ones, and is looking forward to an equally productive year ahead.

Respectfully submitted,

ALBERT M. ANTLITZ, MD, Chairman

ALEX AZAR, MD

HORACE W. BERNTON, MD

NIEL J. BORRELLI, MD

MAX E. BYRKIT, MD

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AD HOC COMMITTEE ON RESOLUTION 1S/77

*Mr. President and Members of the House
of Delegates:*

This Committee has been in existence since November, 1977, when it held its first meeting. Since that time, considerable discussion and activity has taken place in connection with its charge, which is as follows:

"RESOLVED, that Medical School Faculty members and the Practicing physicians of Maryland are urged to become more cost-conscious and to reemphasize the use of the utmost discretion in admitting patients to hospitals and in ordering ancillary services in patient care."

Most of the Committee's attention has been directed to ancillary services and the costs of such services.

The Committee has met with some resistance in connection with a proposal that all physicians who admit patients to general, acute care hospitals receive a copy of the patient's bill when discharged. In this manner, the physician would become familiar with the cost of various tests ordered either by him, by the house staff or on the basis of standing orders.

It has been learned the Health Services Cost Review Commission is collecting data on ancillary tests by admitting diagnosis and by physician and hospital. This would indicate any startling differences between institutions and physicians. This matter is being closely followed by the Committee.

Early after the appointment of the Committee, a survey was carried out by contacting all hospitals to ascertain what tests are performed on all admissions, either on a mandatory basis or by a negative check-off list. The results provided interesting information to the Committee.

Following this, it was recommended that all hospital medical staffs review these standing orders to ascertain the necessity of such orders. All of this took place prior to the national interests and concerns and the public statement by the National Blue Cross Plan that it would no longer pay for mandatory tests and would only reimburse institutions for tests individually ordered by the physician and pertinent to the admitting diagnosis.

In response to inquiries from the press, we were able to reply in a positive manner as to what was being done in Maryland.

The Committee continues to work closely with the Maryland Hospital Association and plans to follow-up its original survey of hospitals with one to see if any changes have occurred since this matter was brought to the attention of Chiefs of Staff at acute care institutions. The MHA will also direct a letter to the hospital administration urging coordination of activity in this connection.

We are also glad to report that the Department of Health and Mental Hygiene, through its Division of Licensing and Regulation, has revoked its rule requiring mandatory tests for all hospital admissions. The Joint Commission on Accreditation of Hospitals did this some time ago.

Your Committee will continue to work on this matter and, hopefully, can report further progress in its next report.

HARRY F. KLINEFELTER, MD
Chairman □

CURATOR

*Mr. President and Members of the House
of Delegates:*

The past year has been very successful, both in the acquisition of new items and in our program to restore existing portraits. The most significant acquisition is a portrait of Daniel Gilman, the first President of the Johns Hopkins University. Dr. Gilman was a speaker at the Faculty's 100th anniversary celebration in 1899 and at the dedication of the Faculty's building on Cathedral Street. This fine portrait, painted by Paul Hulwig, formerly belonged to Howard A. Kelly, MD, and came to the Faculty through the estate of Howard C. Smith, MD.

In addition, a large number of "antique" medical instruments, including microscopes, electrocardiograph machines, X-ray tubes, surgical kits, etc., have been donated to the Faculty. These contributions are regularly listed on the Library Page in the *Journal*.

As of this writing, the last of the "second priority" portraits is at the Purnell Galleries for restoration. This completes a major step in the restoration program begun several years ago. During the coming year, the Faculty's portrait collection will be reevaluated for insurance purposes, and priorities will be reset for needed repairs and restoration.

The Faculty's bronze-plaque portrait of Frank Frick was featured in an exhibit at the Walters Art Gallery in February and March, 1979 and the Faculty was appropriately-credited. It is hoped that additional showings of some of the Faculty's treasures can be arranged in the future.

Respectfully submitted,

E. DAVID WEINBERG, MD,
Curator □

PHYSICIAN/PATIENT RELATIONS

*Mr. President and Members of the House
of Delegates:*

The Physician/Patient Relations Committee maintained a monthly meeting schedule during the past year to consider a variety of issues, including such matters as whether certain proposed corporate designations fall within ethical and legal standards. In rendering ethical opinions regarding the participation by physicians in commercial enterprises, the Committee has maintained the policy that a physician may not participate in a corporation from which a profit is obtained if there is any possibility that the physician's patients could be referred to that corporation for care or for testing. Such matters as approval of announcements of the opening or change of offices have also been routinely reviewed by the Committee.

During the past year, the Committee has been involved in over 20 cases referred by the Commission on Medical Discipline. The nature of these cases has ranged from problems in communication to rather serious disturbance in physician/patient relationships, and instances where physicians have been reported by Federal and State authorities. In each of these cases, every attempt is made to interview the complainant for the purpose of establishing optimal physician/patient understanding, and to conduct a thorough investigation for report to the Commission. Aside from providing written statements, many physicians were interviewed in order to obtain a clearer understanding of the facts surrounding each case. In several instances, questions were raised regarding the quality of medical practice, and the practices were, therefore, referred to an appropriate peer review committee for additional attention.

For the first time, the Committee opened liaison with major industries in the state in order to assist the private sector in reducing employee absenteeism relative to physicians' absent from work notes. In several cases, treating physicians were advised of manipulative behavior on the part of certain employees, after which changes were instituted. The Committee also identified several physicians who were rather liberal in granting medical excuses and at least one of these individuals was reported to the Commission on Medical Discipline. The Committee intends to continue this activity since industry, the profession, and society at large can only benefit from our involvement.

The Committee has continued its function as arbitrator between physicians involved in disputes arising from the practice of medicine. These disputes generally involved the referral of patients and more frequently concerned the distribution of medical records after separation from practice. Although the Committee's role as arbitrator becomes difficult at times, it is strongly felt that this function is exercised fairly and with a minimum of negative feeling.

In this era of cost-consciousness, the Committee continues as it has done for many years, to review requests from third-party carriers for determinations of whether certain fees are within a usual and customary range. These matters are referred to appropriate specialty societies for consideration, and the Faculty forwards the determination to the insurance company. This Committee function is exercised with caution and it may have to be modified due to activities of the Federal Trade Commission on the national level.

Advertising continues to be a matter of consideration as public and professional standards evolve. At the present time, the Committee firmly maintains the policy that Maryland law prohibits physicians from advertising except as provided by regulations of the Board of Medical Examiners. Such regulations have been revised and are now in the Antitrust Division of the Maryland Attorney General's office for a determination of legal sufficiency.

The Chairman wishes to extend his gratitude to each of the Committee members for the many hours they have devoted to the Committee's activities. We are all grateful for the opportunity to serve on this necessary Faculty Committee.

Respectfully submitted,
JOSE M. YOSUICO, MD, Chairman
KATHERINE H. BORKOVICH, MD
LOUIS C. BRESCHI, MD
GERALD A. HOFKIN, MD
STEPHEN JONES, MD
HILARY T. O'HERLIHY, MD
LAWRENCE PINKNER, MD
MARVIN ROMBRO, MD
FRANK F. SCHUSTER, MD
LEX B. SMITH, MD □

MEDICAL ANNALS OF MARYLAND

Mr. President and Members of the House of Delegates:

Continued progress has been achieved toward the publication of a second volume of the *Medical Annals of Maryland*. The intent of this proposed monograph is to present a scholarly account of the Medical and Chirurgical Faculty of the State of Maryland from 1900-25. Included will be resource data on physicians who practiced in Maryland during that period, as well as bibliographic data which will provide reference to all pertinent articles from 1900-78 related to the history of medicine in Maryland. A reader/printer machine has been acquired by the Library so that those interested may review the biographical information compiled by the late John Rührh (1872-1935), during the early part of this Century.

With three exceptions, the segments of Rührh's second volume of the *Medical Annals of Maryland* are now either in print in the *Maryland State Medical Journal*, or are ready for publication during the coming year. The exceptions are

Gastroenterology by Dr. Julius Friedenwald; *Medicine* by Dr. Lewellys F. Barker and *Pediatrics* by Dr. Paul G. Shipley. At this time, the Committee is searching for physicians interested in editing these lengthy manuscripts so that they may better reflect a record of medicine specific to Maryland. Members of the Faculty staff are currently compiling necessary background information regarding the approximate size of the volume in pages, the approximate number of illustrations, the size of the index and other matters so that we can ascertain an estimate of the cost of printing the essays together in a single volume. Once this has been established, the Committee may then carry on a solicitation for advance subscriptions to the volume and in this way, fund the printing of the text. This will be an expensive endeavor and much care will be taken to develop this historical volume at reasonable cost. The Committee appreciates the opportunity to document further the wealth of scientific advancement and tradition inherent in the history of medicine in Maryland.

Respectfully submitted,
HENRY B. WILSON, MD, Chairman
A. McGEHEE HARVEY, MD
R. CARMICHAEL TILGHMAN, MD □

MED-CHI INSURANCE TRUST

Mr. President and Members of the House of Delegates:

The Med-Chi Insurance Trustees serve on the Board of Directors of the Med-Chi Agency and are responsible for the programs offered to the membership.

The Agency staff was reorganized in 1978. A. R. Guidice was terminated and Joseph J. Harrison is directing the overall operations of the Agency. There are now three separate departments: Group programs, Property and Casualty and Life and Financial Planning.

Katherine Downey is in charge of the Group programs. Her department includes the Accident and Health Disability Plan, Major Medical, Business overhead insurance, Group Term insurance and Blue Cross and Blue Shield. The Disability plan is the best in the entire country for the cost. This year, the underwriting requirements were made less strict which will allow members to increase coverages easier. More than \$2,000 of monthly disability coverage is available through the plan at rates far lower than other plans.

The Blue Cross and Blue Shield plan now offers full maternity coverage. This will be important to our younger members and also the employees of the members. Another addition was an alcoholic treatment provision. Diagnostic 4 coverage will be offered as an option to existing Diagnostic 3 coverage.

The Property and Casualty Department includes Professional Liability insurance as well as commercial and personal liability lines. A new office liability package

was developed and offered this year. The INA is the underwriter of this plan specifically designed for the physician at very low costs. Bill Flynn is in charge of the professional liability section and Chip Lewis is our casualty agent, who will visit our members at their request.

The Life Insurance and Financial Planning Department is managed by Carroll Feeley. The Med-Chi Members Retirement Plan falls into this department. Carroll stands ready to assist the members in making a decision regarding their plan. He has the latest information on the plan from the bank and insurance company records.

A new bulletin has been developed for our doctor clients. It contains useful information regarding taxes, finances, and estate planning. The title is "Pulse" and is written to interest physicians.

Harry J. Connolly, MD, the Chairman of the Board, suffered an illness and was unable to continue in this capacity for the entire year. W. Kenneth Mansfield, MD assumed the leadership as Acting Chairman in Dr. Connolly's absence.

The Med-Chi Insurance Trustees are most appreciative of the enthusiastic participation of the members in the programs. This continued support will enable us to make the Agency and its products and service the very best available to doctors in Maryland.

Respectfully submitted,
W. KENNETH MANSFIELD, MD,
 Acting Chairman
HARRY J. CONNOLLY, MD
ADRIAN M. COHEN, MD
ROBERT B. GOLDSTEIN, MD
PAUL F. GUERIN, MD
DONALD T. LEWERS, MD
RICHARD F. MOSCHELL, MD
JOSEPH J. HARRISON, CPA,
 Secretary □

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

Under the Chairmanship of Michael L. Levin, MD, the Committee on Preventive Medicine and Public Health met four times during the 1978-79 year.

A number of pertinent issues were submitted by the Subcommittees on Child Welfare, Maternal Welfare, Medical Aspects of Sports, Infectious Diseases, Immunization Practices and Transportation and were discussed throughout the year.

Representatives from the Committees on Emotional Health, Drugs, Occupational Health and Alcoholism and selected Faculty members with an interest in preventive medicine served on the Committee.

Dr. J. Leonard Lichtenfeld was appointed to serve on the Maryland Cancer Information System Committee of the American Cancer Society. Several other oncologists also were appointed. Via an

ACS grant from the National Cancer Institute, the American Cancer Society plans to establish a statewide system of cancer information centers whereby the public may obtain appropriate information relative to diagnosis, treatment, etc. which may be pertinent to patients with or suspected of having a malignant disease. One of the goals of the Cancer Information centers is to provide up-to-date information in a decentralized manner.

Concern was expressed by the Committee on Preventive Medicine and Public Health surrounding the medical input, if any, that was provided into the organizing of the MCIS and, specifically, the decision to decentralize the program. The Committee on Preventive Medicine and Public Health has grave concern regarding the appropriate training of the personnel assigned to staff the telephones under the proposed system. This matter is presently being pursued within the Committee on Preventive Medicine and Public Health.

The Chief Residents of the Preventive Medicine Departments at Johns Hopkins, the University of Maryland and the State Preventive Medicine Administration were invited and participated as advisory members of the Committee.

At the recommendation of the Committee on Preventive Medicine and Public Health, the Council adopted a policy of "no smoking" at all business and professional meetings of the Faculty. Legislation was introduced both on the House and Senate sides of the Maryland General Assembly which would require "smoking" and "no smoking" sections to be designated in public places. Supportive testimony was presented by the Faculty on these bills, however, strong opposition was expressed by the Restaurant Owners Association and the bill was defeated.

The Subcommittee on Transportation, under the Chairmanship of Rudiger Breiteneker, MD, continues to monitor the physician coverage at the BWI Airport. A member of the Committee on Preventive Medicine and Public Health visited with the medical director of the newly-established BWI Medical Facility and discovered that the Facility is equipped to handle minor injuries and minor illnesses on a walk-in basis. This subject is constantly being studied by this Subcommittee. Legislation repealing the motorcycle helmet law passed the General Assembly this year, despite the medical community's strong objections.

The Subcommittee on Medical Aspects of Sports, under the Chairmanship of Eugene Willis, MD, has worked diligently during the past year on the following resolution:

"RESOLVED, That certified emergency medical technicians, nurse practitioners, physician assistants or any other paramedical group, with appropriate training, be used to cover scholastic sports events, i.e., football games, when a physician cannot be obtained, with the stipulation that if the injury is questionable and in all cases of head injuries, the player may not be returned to the game and

"RESOLVED, That the player must be referred to a physician or appropriate medical facility for evaluation and treatment if necessary."

The Committee on Preventive Medicine and Public Health unanimously endorsed this resolution as presented, and will forward it on to Council in the very near future.

The Subcommittee on Medical Aspects of Sports proposed and the Committee on Preventive Medicine and Public Health endorsed the following resolution:

"RESOLVED, That is the opinion of the Medical and Chirurgical Faculty of the State of Maryland that the use of trampolines should be eliminated in elementary and secondary schools in the State of Maryland."

The Subcommittee on Maternal Welfare of Sports is currently seeking information from the Department of Education on the type of courses available for coaches inasmuch as certification is concerned.

The Subcommittee on Material Welfare, under the Chairmanship of John A. Hawkinson, MD, is currently monitoring the proposed regulations governing the practice of nurse midwives. A public hearing was held in February, 1979, at which time the Subcommittee voiced its strong objections to the regulations as drafted and recommended redrafting of such. Subsequent to the hearing, the regulations were referred back to the Board of Examiners of Nurses and the Board of Medical Examiners for further consideration. Presently, the two groups are attempting to resolve their differences.

The Subcommittee requested State Senator Rosalie Abrams to introduce legislation declaring all maternal deaths as medical examiner cases. Inasmuch as 60% of maternal deaths currently receive autopsies, the General Assembly felt no need for this legislation; however, this bill will be introduced again into the 1980 Legislature by the Subcommittee on Maternal Welfare.

Approximately five abortion facilities were inspected by the Subcommittee during the past year and all were found to be in conformance with the Standards for Outpatient Abortion Facilities.

The Subcommittee on Infectious Diseases, under the Chairmanship of Clayton L. Moravec, MD, was presented with a research proposal as prepared by the Nosocomial Infection Program of the State Health Department, of which Edda Sonnenberg, RN, is Chief. An objective of the proposal is to demonstrate a 20% reduction in length of stay due to nosocomial infections within two years of implementing this strategy in participating hospitals. The Committee declined to accept the proposal as presented, inasmuch as the scope is felt to be too broad, the in-depth program is lacking specificity and if a study is to be undertaken, the methodology must be more clearly defined.

The Subcommittee on Child Welfare, under the Chairmanship of Thomas E.

Reichelderfer, MD, considered legislation for a Child Restraint Law, modeled after the current law in Tennessee.

Several legislators were contacted and requested to introduce such a bill requiring children under the age of four to be equipped with a child restraint system. Despite the many physicians who testified in favor of this bill, it went down in defeat.

Liaison was established with the newly-created Office for Children and Youth of the State of Maryland.

Respectfully submitted,
MICHAEL L. LEVIN, MD, Chairman
RUDIGER BREITENECKER, MD
JOHN G. GITTZUS, MD
KARL M. GREEN, MD
D. CROSBY GREENE, MD
JOHN A. HAWKINSON, MD
JOHN M. KRAGER, MD
J. LEONARD LICHTENFELD, MD
NOEL D. LIST, MD
JULIUS LOEBL, MD
CLAYTON L. MORAVEC, MD
DAVID M. PAIGE, MD
JOHN L. PITTS, MD
LOUIS J. PRATT, MD
THOMAS E. REICHELDERFER, MD
EDWARD A. SAWADA, MD
GERALD J. SCHIPPER, MD
EDYTH SCHOENRICH, MD
ELIZABETH B. SHERRILL, MD
RUTH SINGER, MD
SAMUEL BLUMENFELD, MD
DONALD K. WALLACE, MD
EUGENE WILLIS, MD
JAMES P. G. FLYNN, MD
ABRAHAM SCHNEIDMULH, MD
THOMAS PEARSON, MD
EBENEZER ISRAEL, MD
JAMES TENNEY, MD
CHRISTIAN MASS, MD □

DRUGS

Mr. President and Members of the House of Delegates:

With each year, the activity of this Committee becomes busier and busier. During this year, we have met monthly and have interviewed 14 physicians during meetings at the Faculty Building; made visits to at least three physicians' offices; considered 20 amphetamine regulation exemption requests as a whole Committee and have approximately 200 reports from the Division of Drug Control in our file, awaiting some kind of action. The Division of Drug Control continues to monitor pharmacies throughout the state, forwarding reports to this Committee of the prescribing of controlled drugs. Each of these reports requires some action by the Chairman of the Committee, who is also designated as a Consultant to the Department of Health and Mental Hygiene. Usually, initial correspondence with the physician is all that is required

to bring to his attention the fact that there are regulations restricting the prescribing of amphetamines or that additional care might be needed in the prescribing of classified drugs.

During this period of time, we have been contacted by county police departments requesting our assistance in reviewing the practice of physicians who have seemed to be prescribing controlled drugs inappropriately. Other agencies contact this Committee as well. The Health Services Review Division of the Medical Assistance Program requested assistance of this Committee in reducing the quantity of certain drugs being prescribed by physicians, because of the high cost to the Medicaid program; however, there was some difference of opinion as to the criteria for the prescribing of these medications and the Committee has insisted on the physician's right to prescribe according to his best medical judgment.

The new regulations concerning the prescribing of amphetamines have still not been promulgated. A hearing was held and the Committee has disputed two points in the proposed regulations, but has not received confirmation or denial of these points. The final regulations are, we are told, on the desk of the Secretary of Health and Mental Hygiene for signature.

The Committee was requested to assist in determining an appropriate manner in which health care in the Cecil County Jail should be administered and how prescription drugs should be issued. From this, the Committee has developed an interest in the delivery of health care in other county jails. Mrs. Claire Evans, Pilot Project Director for the Project to Improve Care in Jails, will meet with the Committee in the next few months to discuss ways of involving the Committee in this area.

The Maryland Drug Abuse Advisory Cooperative Committee was disbanded during the past year, as its work has been assimilated into other groups.

The Committee took a strong stand opposing the advertising in national newspapers and magazines of an "anti-calorie" capsule and learned that through the efforts of other concerned groups as well, including the FDA, it has been taken off the market. This was an example of absolutely false and misleading advertising, which could have been detrimental to the health of the public.

The Committee continues to express concern for the prescribing of Preludin, since this anorectic drug is meant to be prescribed only for short-term use, according to the PDR. Largely through the efforts of this Committee, however, we believe many physicians have abandoned this method of treating obese patients and have restored to more efficacious means.

The Chairman concluded his tenure as Chairman of this Committee with the May, 1979 meeting and wishes to express his gratitude to all members of the Committee and to staff for the cooperation and dedication shown throughout the past few years.

Respectfully submitted,
KENNARD L. YAFFE, MD, Chairman
RODNEY L. BRIMHALL, MD
WILLIAM T. DIXON, MD
CHARLES R. GOSHEN, MD
STEPHEN A. HIRSCH, MD
LEON E. KASSEL, MD
NOEL D. LIST, MD
JOHN A. SINGER, MD
ROBERT L. YOUNG, MD
THOMAS G. SINDERSON, MD □

OCCUPATIONAL HEALTH

Mr. President and Members of the House of Delegates:

According to its Bylaws, the Occupational Health Committee shall study and report on all phases of occupational health. Throughout the year, the Committee has directed its efforts toward fulfilling this responsibility. As a new year approaches, we shall work toward continued improvement in this area and maintain effective liaison with organizations/institutions concerned with the health and safety of the working person.

Action of the Committee for the past year is as follows:

1. The Committee discussed action of the Department of Health and Mental Hygiene to encourage the reporting of suspected job-related diseases by physicians. It is vital that this information be reported to the Health Department in order to properly identify employment areas of risk. The Health Department has developed guidelines for the reporting of any suspected occupationally-related diseases. Copies will be forwarded to all physicians in Maryland in the near future. The importance of reporting any suspected job-related illness cannot be emphasized too strongly. The Committee recognizes the difficulties facing the Health Department in this undertaking and agreed to assist and support its efforts in this area. Cooperation of physicians employed in industry, as well as private practice, is the key factor if this project is to be successful.

2. In response to a request from the Division of Labor and Industry, the Committee reviewed a proposed policy statement to establish a comprehensive strategy to eliminate harmful exposures in working environments throughout the state which are known or suspected of causing cancer. While the Committee agreed with the objectives outlined in the statement, its success will depend greatly on whether the Division and the Health Department can work amicably together.

3. At the request of the Preventive Medicine and Public Health Committee, permanent liaison has been established with the Occupational Health Committee.

4. Numerous inquiries concerning industrial/occupational matters were given prompt consideration and response.

5. The Committee sponsored one of the scientific sessions which took place during the Annual Meeting. The formal pre-

sentations were delivered by Stuart M. Brooks, MD, Associate Professor of Medicine and Environmental Health, University of Cincinnati Medical Center and Edward A. Emmett, MD, Professor of Environmental Health Sciences of the Johns Hopkins School of Hygiene and Public Health. Their presentations contributed greatly to the overall success of the meeting.

6. The Committee is planning to conduct a survey to determine the number of physicians employed in occupational medicine on a full-and/or part-time basis.

The Chairman would like to thank all Committee members for their invaluable assistance and support throughout the year.

Respectfully submitted,
CHRISTIAN S. MASS, MD, Chairman
PETER CHODOFF, MD
ELLIOTT R. FISHEL, MD
DAVID W. FOUTS, MD
DIONISIO GARCIA, JR., MD
JOSEF J. GOLDSTEIN, MD
ARTHUR T. HALL, JR., MD
FREDERICK N. PEARSON, MD
LUCIUS W. LEEPER, MD
WILLIAM J. McCLAFFERTY, JR., MD
JAMES A. ROBERTSON, MD
DONALD J. ROOP, MD
GHOLAM R. SADJADI, MD
LEOPOLDO SALAZER, MD
ARTHUR A. SERPICK, MD
Advisory Members
GEORGIANA GOODWIN, MD
KATHERINE FARRELL, MD □

LONG-TERM CARE

Mr. President and Members of the House of Delegates:

The past year has seen consistent progress in opening appropriate channels for the improvement of quality of care in the State's Skilled and Extended Care Facilities.

In order to focus on issues in the State legislative arena, a meeting was held with State Senator Rosalie Abrams and Delegate Torrey C. Brown, MD in November, 1978. Both legislators indicated that they were quite cognizant of bureaucratic obstacles encountered by geriatric patients as a result of the division of responsibility among the Office on Aging, the Department of Human Resources and the Department of Health and Mental Hygiene. Both have indicated a strong desire to work toward the alleviation of these problems and the Committee has assisted in several areas.

A meeting was held with the Director of the Office on Aging in order to get a clearer description of the organization and function of this unique department. Particular attention was paid to the liaison the Office on Aging has with the Legislature, as well as with the way it handles complaints involving nursing

homes and physicians. Since this meeting, the Committee and Faculty staff have assisted in inquiries of this type.

The Director of the Mental Hygiene Administration also met with the Committee to discuss the four regional State facilities for chronic care. The Committee was also apprised of statistical data describing the reduction of elderly inpatients in the State mental hospitals. Deinstitutionalization of patients is a complex issue requiring the development of improved social, medical assistance and transportation systems.

In order to address the complex socioeconomic issues, over 100 Medical Directors and Principal Physicians throughout the state were invited to attend a seminar related to the provision of quality medicine in the regulated environment of long-term care. Representatives from various State agencies gave presentations and answered questions regarding policies of their agencies. Those agencies represented were the Division of Licensing and Certification, Professional Standard Review Organizations, Baltimore City Hospitals and Faculty staff. It was also during this meeting that the groundwork for the establishment of a Maryland Chapter of the American Association of Nursing Home Physicians was laid.

The Committee wishes to express its appreciation for being given the opportunity to address the wide-ranging issues in long-term care, and would again congratulate those physicians in Maryland for their leadership in this field.

Respectfully submitted,
EDMUND G. BEACHAM, MD,
Chairman

TILL BERGEMANN, MD
JAMES CHACONAS, MD
MAX FRANK, MD
KENNETH KRULEVITZ, MD
HERBERT J. LEVICKAS, MD
NOEL LIST, MD
FRANCES NORRIS, MD
ALLAN H. MACHT, MD
AUBREY D. RICHARDSON, MD
DONALD C. ROANE, MD
R. LANE WROTH, MD
BERNARD J. YUKNA, MD
JOSEPH R. GLADUE, MD
SAMUEL MORRISON, MD
M. WILLIAM VOSS, MD □

EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Emotional Health held eight meetings during 1978-79 to discuss the delivery of mental health services, the current trends in the practice of psychiatry in the state and increasingly important legislative matters.

With the appointment of Dr. Lino Covi to the Governing Body of the Central Maryland Health Systems Agency, Dr. Ronald Taylor was appointed to the Mental Health Coalition. The Coal-

tion's statutory task is to give technical assistance to those hospitals which so desire when making application for approval of a psychiatric wing within their hospital.

Dr. Samuel Blumenfeld served as liaison to the Committee on Prevention Medicine and Public Health during this past year.

Dr. Hirsch was the representative appointed to serve on the Legislative Committee once again. A great deal of legislation which affected the Committee, either directly or indirectly, was discussed by the members over the past year. The Committee on Emotional Health supported the Legislative Committee in its efforts to establish legislation which would exempt all physicians from the jurisdiction of the HSCRC. This bill was amended in the Legislature, in a manner totally unacceptable to the medical profession, and was subsequently defeated by the Faculty.

Much concern of the Committee was the problem of paraprofessionals desiring to practice independently—psychologists in particular. HB 1084, as introduced into the 1979 Legislature, would have allowed psychologists to commit patients without the advice of a physician. Despite the Committee's strong objections, the bill was enacted with the following amendments:

1. The admission of a minor by a parent to a child or adolescent unit for the purpose of diagnosis and consultation which is assented to by two physicians, OR ONE PHYSICIAN AND ONE CERTIFIED PSYCHOLOGIST, may be treated as a voluntary admission for a period not to exceed 20 days.

2. Each application for admission to a facility shall be accompanied by the certificates of two physicians, OR THE CERTIFICATES OF ONE PHYSICIAN AND ONE CERTIFIED PSYCHOLOGIST that the prospective patient has a mental disorder, and for his protection or others, needs inpatient care or treatment.

3. If the petitioner is a peace officer of the rank of sergeant or higher, a duly-licensed physician, A CERTIFIED PSYCHOLOGIST or the local health officer, as described by Sections 46 and 47 of Article 43 or his designee, the emergency admittee shall be taken into custody by a peace officer and transported to an emergency facility where he may be detained for not more than 24 hours without judicial endorsement.

Several bills regarding adoption laws were introduced, however the Committee was of the opinion that this is much more of a social concern, rather than a medical one.

The Committee continued their efforts to determine what type of emergency psychiatric services were available in specific regions in Maryland. Responses received indicated that the services appear adequate, however, a mechanism to assure that these facilities are indeed functioning as the propose to be remains to be found and this matter is presently

under further consideration within the Committee.

Psychiatric training for paramedics was the subject of discussion at several meetings. The President of the Board of Fire Commissioners was contacted in an effort to obtain whether or not psychiatric training was being provided to paramedics and under whose supervision. The Baltimore City Medical Society has established a Medical Advisory Committee to oversee the operation of the ambulance service. A two-day, 16-hour program was developed which included subject material dealing with alcohol related problems, drug abuse programs, violent patient managements, rape and child abuse crisis, suicide prevention and disaster crisis.

The subject of what appeared to be an epidemic of young teenaged pregnancies and how this Committee might handle the primary prevention of such was discussed by the Committee on several occasions. Dr. Janet Hardy recently published an article, *Long-Range Outcome of Adolescent Pregnancy* which the Committee felt adequately answered its concerns.

Dr. Lino Covi served as liaison from the Maryland Psychiatric Society to the Committee on Emotional Health, creating a much more direct line of communication between the two groups. Minutes were exchanged and many legislative matters were mutually-discussed.

Respectfully submitted,
STEPHEN A. HIRSCH, MD,
Chairman
IDO ADAMO, MD
SAMUEL BLUMENFELD, MD
LINO COVI, MD
ARGUSTO J. ESQUIBEL, MD
IRENE L. HITCHMAN, MD
WILLIAM MAGRUDER, MD
GUILLERMO OLIVOS, MD
FREDERICK P. POKRASS, MD
BRUCE L. REGAN, MD
JOHN D. SCHULTZ, MD
RONALD J. TAYLOR, MD
H. THOMAS UNGER, MD □

Doctors Take Note:

Oct. 5, **Nutrition**—College Park Campus Adult Educ. Ctr. For further info. contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956 (as well as for all courses below.)

Oct. 10-12, **Computer Tomography Symposium: Body CT and Neuro CT**, Internatl. Hotel, BWI Airport.

Oct. 26-27, **Prac. Clin. Endocrinology**, Internatl. Hotel, BWI.

Nov. 16-17, **Symp. on GI Cancer**, Internatl. Hotel, BWI.

Dec. 7-8, **Symp. on Gynecologic Oncology**, Internatl. Hotel, BWI.

MEDICOLEGAL

Mr. President and Members of the House of Delegates:

A substantial part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of a lawyer and a physician. Throughout the year, the Medicolegal Committee has worked toward improving the relationship between members of both professions by encouraging a mutual exchange of information and cooperation in order that the needs and interests of the public are best served. As a new year approaches, we shall continue to consider disputes involving both professions, and pursue amicable solutions to these problems.

Action of the Committee for the year is as follows:

1. Twenty-five cases are currently being considered by the Committee which are in various stages of resolution. The Committee has been successful in resolving 23 disputes satisfactorily.

2. Considerable time and effort have been devoted to revising the Medicolegal Code of Cooperation. A special subcommittee has worked long and hard in the development of new language and major changes in the format of the Code. As a new year approaches, our efforts will be directed toward early completion of this most difficult task.

3. The Committee was requested to comment on the appropriateness of "Authorization and Agreement to Pay Forms" when Workmen's Compensation cases are involved. Our response indicated that all fees are subject to the Commission's approval, and disbursement of any award(s) are subject to regulation of the Commission.

4. Numerous inquiries from physicians, as well as the general public, concerning medicolegal matters were given prompt attention and response.

The Chairman would like to thank all members of the Committee for their invaluable assistance and support throughout the year.

Respectfully submitted,

JEROME P. REICHMISTER, MD
Co-Chairman

M. KING HILL, JR., ESQ., Co-Chairman

EMIDIO A. BIANCO, MD

JOHN J. CONROY, MD

ELLIOTT R. FISHEL, MD

LORENZO MARCOLIN, MD

CURTIS MARSHALL, MD

RICHARD MUNFORD, MD

JOHN J. TANSEY, MD

ISRAEL H. WEINER, MD

JOHN L. SCARBOROUGH, ESQ.

ROBERT J. RYAN, ESQ.

PAUL V. McCORMICK, ESQ.

GEORGE J.

GOLDSBOROUGH, JR., ESQ.

R. ROGER DRECHSLER, ESQ.

MARVIN ELLIN, ESQ.

JAMES M. GABLER, ESQ.

STANLEY I. MORSTEIN, ESQ.

PATRICK A. O'DOHERTY, ESQ.

ALBERT GINSBERG, ESQ.

JOHN GLENN, ESQ. □

EXECUTIVE DIRECTOR

Mr. President and Members of the House of Delegates:

A question is often posed to the Executive Director—"Just who *does* set policy for the Faculty?" It is interesting that this question is even asked, for the only policy-making bodies of the Faculty are as defined in the Faculty's Bylaws. Ultimately, the policy-making body of the Faculty is the House of Delegates, which has the final say on all matters involving Faculty activity. Between meetings of the House of Delegates, the Bylaws give this authority to the Council, excluding the right of overruling any action of the House of Delegates. The Executive Committee of the Council, composed of the Officers, can advise the staff on matters of immediate importance but, in fact, cannot establish policy except in an emergency situation.

Over the years, Faculty policy has been developed by the two bodies authorized to establish such policy. These decisions have been duly-recorded in a *Policy Book* maintained by the Faculty's Executive Director and from the "memory bank" of staff people who frequently can recall with amazing detail and clarity the position of the Faculty on issues that go back many years.

These position statements are taken into account, for instance, when a particular piece of legislation is being considered in Annapolis and there has not been time to convene a meeting of the Legislative Committee. These positions are also taken into account almost weekly as various Faculty Committees meet to discuss issues and to determine what action, if any, is to be taken.

Statements that the Executive Director makes policy, as can be seen from the above, are inaccurate, and such decisions have never been made by the officer.

It is important that all members realize these facts. The House of Delegates, in which proportional representation based on component society membership is held by each component medical society makes policy, which is as it should be. With the new Council, composed again of proportional representation from each component medical society, this also provides for grassroots input into all policy positions of the Faculty.

It is important that persons serving in these capacities representing their local physicians make their views known.

As always, the work of the Executive Director is reflected in the various reports of Committees, officers and others. Without the assistance of a first-class staff, our efforts would be for naught.

Respectfully submitted,

JOHN SARGEANT, CAE
Executive Director □

HOSPITAL-AFFILIATED PHYSICIANS

Mr. President and Members of the House of Delegates:

This Committee held only one formal meeting during the past year. Specifically, this was called to discuss legislation as proposed by the Legislative Committee, in concert with specialty societies, dealing with the HSCRC.

During the year, this Committee has continued to redefine its major purpose and analyze the directions it should take in carrying out its mandated function. There have been two main areas of interest. The first is to make the "Physician who practices within the hospital setting" aware that Med-Chi and this Committee are sensitive to his concerns and anxious to help with problems which develop. The second is to make other physicians aware that the bureaucracy is tending to see little difference in the physician-hospital relationship no matter how much or little time is spent within the hospital.

Advice has been given in several cases where physicians have sought help prior to entering into contracts with Hospitals for their professional services.

Respectfully submitted,

LAWRENCE E. HOLDER, MD, Chairman

ALBERT M. ANTLITZ, MD

CHARLES J. E. ARNOLD, MD

GEORGE A. BEDON, MD

JOSEPH S. BRITO, MD

PAUL BURGAN, MD

BENTLEY BURNHAM, MD

ROBERT G. CASTADOT, MD

ROBERT E. CRANLEY, MD

C. JAMES DUKE, MD

PETER M. FAHRNEY, MD

PHILIP J. FERRIS, MD

SAMUEL L. JOSEPH, MD

LEON E. KASSEL, MD

ROBERT R. KENT, MD

LEON R. LEVITSKY, MD

JOSE MARTINEZ, MD

SELVIN PASSEN, MD

CARLOS N. PATALINGHUG, MD

SAMUEL R. PINES, MD

THOMAS R. PRICE, MD

IBRAHIM A. RAZZAK, MD

CHARLES SAMORODIN, MD

MICHAEL L. SHERMAN, MD

AJAIB S. SIDHU, MD

GERALD A. SWEENEY, MD

DEAN R. TAYLOR, MD

WILFRED T. TUMBUSCH, MD

RICHARD A. YOUNG, MD □

MARYLAND STATE SCHOOL HEALTH COUNCIL

Mr. President and Members of the House of Delegates:

The Maryland State School Health

Council in this recent past year has been chaired by Louise Blauvelt, RN, MA. Other officers included, Natalie Mariotti, MPH as Vice Chairperson; Richard L. Gamble, MA, MEd, as Secretary and Martha Taylor Schipper, MD, MPH, as Treasurer.

The School Environment was the subject of the fall conference held in November, 1978. This meeting emphasized current issues related to the school environment, contributions of other disciplines in its development and the environmental needs of students with handicaps. The Adolescent and Alcohol was the timely subject for the spring meeting held in Ocean City, MD. The problem of adolescent drinking was explored relevant to etiology, prevalence, peer pressures and its effects on health and scholastic achievements.

The meetings held through the course of the year in addition to these seasonal conferences, as in the past, included health and student-related subjects. On review of the minutes of the meetings, some of the issues discussed that would be of interest to physicians were vision screening, school lunch programs, developmental evaluation services for the pre-school child, standards for health services and sports medicine.

This is a well worthwhile organization and its interest in the health of our school children cannot be over-emphasized. As I complete my term of representation, I am delighted to say it has been a pleasure to have been associated with the Council.

Respectfully submitted,
RAYMOND P. SRSIC, MD □

JOINT PRACTICES

Mr. President and Members of the House of Delegates:

Optimal health care and effective health planning require interaction and cooperative efforts between all health care providers. As a result of the reorganization in 1976 of the Joint Practices Committee, we believe we have opened larger avenues of communication between all allied professions, in that representatives of all health and social fields can now serve as a united group to consider areas of mutuality of practice in the provision of quality health care. It is our view that the Committee provides a forum to discuss areas of mutual concern, to consider problems common to health and social professions and to work toward satisfactory solutions of these problems.

Immediately following is a report of the Committee business for the year 1978-79:

1. The Committee devoted further discussion to the administration of physical therapy by health professionals other than physicians and physical therapists. Until such time that joint regulations are issued by the Board of Physical Therapy and the Board of Medical Examiners, only physicians and physical therapists can administer physical therapy. This is in accordance with existing law.

2. The problems resulting from the use of multi-prescription blanks by physicians were discussed at length. While there is no law prohibiting their use, the pharmacist representatives outlined two reasons why they should not be used: first, this type of Rx blank frequently includes prescriptions calling for both Class II and Class III drugs. The pharmacist, however, is required to keep separate records of all Class II drugs, necessitating the setting up of two separate filing systems. Secondly, since numerous drugs are listed on the Rx blank, the physician merely checks off the drug to be used in the prescription. In times of stress, it would be very easy to check off the incorrect drug. For these reasons, their use will be discouraged.

3. At the request of the Maryland State Health Planning Agency, the Committee reviewed and accepted a position paper concerning a study on nursing manpower in Maryland, submitted by the Health Manpower Committee in response to recommendations of the Maryland Commission for Nursing.

4. Guests have been invited to attend meetings to express their concerns which relate to areas of practice within the health and social professions.

5. The Committee reviewed legislation enacted this year affecting the various health and social professions serving on the Committee.

6. The Committee was advised that there apparently exists within the medical community a great misunderstanding with respect to how the physician assistant wishes to conduct his/her practice, in that there are many individuals who believe the physician assistant wishes to work independently of the physician. The PAs who serve on the Committee have indicated this is totally incorrect, and requested the assistance of the Committee in resolving this situation. As explained to the Committee, the PA does not want to work independently or in competition with the physician, but rather in collaboration with him, enabling the physician to provide maximum medical services to his/her patients. This is currently being pursued with the Board of Medical Examiners.

As a new year approaches, the Committee is hopeful it shall continue to enjoy the assistance and support of those professions now serving on the Committee. I would also like to express my appreciation to the members of the Committee for giving their time and energies to the matters brought before the Committee during the year.

Respectfully submitted,
MARY McCANN SPICER, RN,
Chairperson
Physicians
ROBERT SPICER, MD
ELLIOTT R. FISHEL, MD
Registered Nurses
GLENDA ROBERTS
Licensed Practical Nurses
GEORGIA J. PAYNE

GLADYS E. PEEVY
Physician Assistants
KATHERINE D. KAMINSKI
RICHARD ROHRS
Occupational Therapists
DIANE MASLEN
E. H. PEPMEIER
Physical Therapists
ERNEST A. BURCH, JR.
JAMES A. BARNHART
Dental Hygienists
MARY LOU EVERETT
LINDA RUBINSTEIN
Pharmacists
ROBERT SNYDER
PAUL FREIMAN
Nutritionists
CAROL LOOMIS
JEAN SMITH
Social Workers
JEAN DOCKHORN
MARY DEMORY
Speech Pathologists and Audiologists
ROGER WALTERS
Psychologists
DR. JULIAN ABRAMS
DR. LAWRENCE DONNER
Dentists
DR. WILLARD PARSON
DR. STANLEY W. McGHEE
Podiatrists
DR. NEIL M. SCHEFFLER
LARRY I. SHANE
Optometrists
MARVIN L. GETZ □

ALCOHOLISM

Mr. President and Members of the House of Delegates:

In its first year of operation as a full, standing Committee of the Medical and Chirurgical Faculty, the Committee on Alcoholism has held regular monthly meetings to address the medical and socioeconomic issues relative to the disease of alcoholism. This has been done in order to exercise the charge to the Committee of working toward educating the public and the profession with respect to alcoholism as an illness.

The Committee has maintained its broad membership, drawing upon the expertise of physicians, as well as advisory members from the Department of Health and Mental Hygiene, the clergy and representatives of major industries in the Baltimore metropolitan area.

In the area of public education, the Committee has met with representatives of the Maryland State Department of Education regarding existing curriculum on health education and alcohol use and traffic safety developed in 1973. The Committee determined that this curriculum, which is used in most public schools, is in need of updating in order to better present psychiatric and socioeconomic data regarding the effect that alcoholism has on alcoholics and their families. We are pleased to report that the Committee's

interest in this area was well-received and meetings are planned to be held with the Maryland Association of Boards of Education and also the Maryland Congress of Parents and Teachers.

The Committee reviewed a proposal from the Central Maryland Health Systems Agency calling for a requirement that health providers document all alcohol related hospital in-service training programs prior to the issuance of a Certificate of Conformance or Proposed Use of Federal funds by the planning agency. This proposal was reported to Council, after which formal opposition to this recommendation was approved. The Committee is pleased to report that the document was revised so that there would be no mandate for physicians to take Continuing Medical Education courses in one specific disease entity in order to maintain hospital privileges. The Committee continues to maintain liaison with the planning agency through a representative on the Mental Health Coalition. In addition, the Committee has offered its expertise to all health planning agencies in areas relevant to alcoholism.

The Committee has also devoted much attention to the reimbursement policies of insurance carriers for the treatment of alcoholism. Even though alcoholism has been declared an illness with psychological and organic factors by the American Medical Association and by the Faculty, major insurance carriers, including Blue Cross, continue to utilize only psychiatric criteria in computing costs of carriers, including Blue Cross coverage. The Committee has initiated liaison with major insurance carriers in order to work toward broadening the coverage for the benefit of patients as well as to contain costs. In doing so, the Committee assisted in the development of Resolution 1A/79 introduced by the Baltimore City Medical Society Delegation and adopted by the House of Delegates on May 5, 1979.

The Committee on Alcoholism will continue to address the many issues in this area. The Chairman wishes to take the opportunity to express his appreciation to each Committee member for their services to the Faculty.

Respectfully submitted,

JOHN H. HIRSCHFELD, MD, Chairman
CONRAD B. ACTON, MD
RICHARD BAUM, MD
JOSEPH F. CHAMBERS, MD
WILLIAM T. DIXON, MD
DANIEL C. W. FINNEY, MD
LEWIS P. GUNDRY, MD
SEANA HIRSCHFELD, MD
HARRY F. KLINEFELTER, MD
LEOPOLDO SALAZAR, MD
ABRAHAM M. SCHNEIMUHL, MD
ROLAND T. SMOOT, MD
IRVING TAYLOR, MD
MAXWELL N. WEISMAN, MD
JAMES E. WHEELER, MD
CHARLES WHITFIELD, MD

JOSE M. YOSUICO, MD
SANDRA HATHAWAY, RN
MR. LUDWIG L. LANKFORD
REV. HARRY E. SHELLEY
MR. THOMAS N. WALKER
MR. PHIL McKENNA

PEER REVIEW

Mr. President and Members of the House of Delegates:

This has been a busy year, sometimes rewarding and often frustrating. The Committee held nine meetings, each lasting from 3½-5 hours.

The following statistics only begin to tell the story of the activity of this Committee:

Physicians interviewed at Faculty Building	9
Physicians interviewed at their offices	22
Recommendations for disciplinary action	12
Referred to Component Societies for review	16
Pending with Components, Commission or Med-Chi	52

These cases do not include cases referred directly to the component societies by the Commission on Medical Discipline where Med-Chi is not involved.

It has become increasingly important for peer review committees, whether at Med-Chi or at the component level, to meticulously plan and document every review of a physician's practice. As the investigating arm of the Commission on Medical Discipline, it is every peer review committee's responsibility to present reasonable evidence of less than good practice which can stand close and unbiased scrutiny. There is some feeling that this may not be the proper role of physicians; however, it is vital that everyone be given "due process" before any disciplinary action is taken against them. There is no substitute for careful and thoughtful peer review, and the physician being reviewed has a right to expect it.

Because the Med-Chi Peer Review Committee has had perhaps the widest experience in conducting peer review (although some component societies have, indeed, been extremely active and effective), a seminar on the methodology of peer review is planned for the latter part of this year, in cooperation with the Commission on Medical Discipline. Video tapes will be prepared of mock peer review committee and Commission hearings, which other peer review committees may find useful. Representatives of component and specialty societies have an open invitation to meet with the Med-Chi Peer Review Committee to discuss any problems they may be having or to obtain assistance in conducting their own reviews.

My tenure as chairman will end with the Annual Meeting, and it is with mixed pride and sadness that I leave the Committee. I believe we have opened up

some new opportunities for the physicians in this state to improve the quality of patient care.

Respectfully submitted,

JOSEPH I. BERMAN, MD, Chairman
KATHERINE H. BORKOVICH, MD
MAX E. BYRKIT, MD
BARRY M. COHEN, MD
NORRIS L. HORWITZ, MD
SERUCH T. KIMBLE, JR., MD
EDWARD J. KOWALEWSKI, MD
HILBERT M. LEVINE, MD
DAVID S. McHOLD, MD
EUGENE R. McNINCH, MD
DEZSO K. MERENYI, MD
LAWRENCE D. PINKNER, MD
JEROME P. REICHMISTER, MD
SIDNEY B. SEIDMAN, MD
HARRY M. WALEN, MD
ALAN C. WOODS, MD
MEHDI L. YEGANEY, MD

PUBLIC RELATIONS

Mr. President and Members of the House of Delegates:

This year saw the realization of a number of long-term projects. The Green-spring Dairy used a health information panel describing the Heimlich Maneuver supplied by the Faculty during the month of March, 1979. A credit line for Med-Chi also appeared on the panel. This was the result of nearly a year of negotiation with a number of dairies.

The Tel-Med telephone health information system will be implemented in Maryland in the near future with the Faculty taking the lead. Coordination of the project, which includes participation from both Baltimore City and Baltimore County Medical Societies, the Health and Welfare Council of Maryland, and Blue Cross and Blue Shield among others, will be in the hands of the Faculty. The statewide project is an ambitious one which will require outside funding in excess of \$100,000 for the purchase of the equipment for 15 locations around the state, representing the direct-dial calling areas. Work on a statewide system has been underway for two years. Subcommittees with representation from all areas of the state and from various interested groups have been formed to implement various aspects of the program—funding sources, local sponsor requirements and equipment purchase. The Committee decided to use the Tel-Med equipment and tapes after examining a number of alternatives.

The Faculty cooperated in the American Medical Association national advertising campaign, placing approximately \$4,000-worth of advertising in local newspapers throughout the state.

WBJC-FM (92.6) approached the Faculty in November, 1978 requesting participation in a telephone radio talk program. Council approved funding for the program, called *Consultation*. The show is heard every other Wednesday evening

from 6:30-8 PM. This program gives the Faculty some on-going media exposure that has been lacking in the recent past.

Public Relations Chairman Raymond J. Donovan, Jr., MD received a First Place award in the AMA speakers' contest in the radio interview category. J. Roy Guyther, MD, Faculty Council Vice Chairman, won a Second Place award for presentation before a professional audience in the same contest. As a result of these two awards, the Faculty received checks totaling \$1,500.

Dr. Donovan is a member of the AMA National Speakers Bureau, as well as being a spokesman for the Faculty. In these two capacities, he completed a total of 18 assignments during the year, including a debate on National Health Insurance with Congressman James Corman at the University of Pennsylvania.

As part of an on-going communication program with representatives of the major media outlets, Faculty President Francis C. Mayle, MD, Executive Director John Sargeant and Communications Director Elza Davis met with the members of the *Sunpapers* editorial staff to discuss matters of mutual interest. The cost of health care was high on the list of items mentioned by the editors. They wanted to know why the costs are high, and what physicians are doing to help. The conversation was wide-ranging and served to reinforce the Faculty's position as a resource for medical information in the community.

Respectfully submitted,
RAYMOND J. DONOVAN, JR., MD,
Chairman
J. HOWARD BEARD, MD
RONALD B. CAMERON, MD
MRS. PAUL CHANG
ROBERT E. CRANLEY, MD
WILLIAM J. R. DUNSEATH, MD



RAYMOND J. DONOVAN, JR., MD
Public Relations Committee Chairman
(Photo by Tadder, Balto.)

EDWARD D. LAYNE, MD
SOL B. LOVE, DDS
MAX J. MILLER, MD
PAUL A. MULLAN, MD

Consultation Schedule:	
Moderator:	John Stupak
Alternate Wednesdays,	6:30-8 PM
Aug. 22nd:	
David Hungerford, MD:	"Artificial Joints"
Sept. 5th:	
Raymond J. Donovan, MD	and Sr. Catherine Grace:
	"Hospice"
Sept. 19th:	
Maxwell Weisman, MD:	"Alcoholism"
Oct. 3rd:	
William Dunseath, MD:	"Skin Problems"

**PHYSICIAN
REHABILITATION**

Mr. President and Members of the House of Delegates:

This Committee met 10 times in the past year to discuss a wide variety of subjects and problems. New ideas are constantly being presented and the need for additional physician and public education becomes more and more apparent. Other professional groups (nurses, dentists and lawyers) have sought our advice in setting up similar types of programs. All possible cooperation is being given by members of this Committee.

The following statistics will indicate to some extent the effectiveness of the Committee to date:

Total number of physicians reported since inception of the Committee	61
Alcohol dependent	26
Other chemical dependency	14
Both	7
Psychiatric illness	13
Physical illness	1
Improved or recovered	31
Currently in treatment	12
Unable to contact or refused assistance	5
Left state or retired	5
Died	2
Returned to abuse	6

One of the most valuable and important advances accomplished in this year was the establishment of a new group therapy program in Baltimore. This program is about full at this time, and plans are being made for additional therapy programs to be set up in both the eastern and western parts of the state.

Another idea which has been pursued is that of preparing some sort of program which would produce an insight into

those factors which might indicate the potential of abuse or addiction to chemical substances. Representatives of the University of Maryland School of Medicine are investigating the possibility of devising a questionnaire to be presented to medical students as well as to practicing physicians, which would be used to anticipate possible future problems. It is acknowledged that this is a very difficult and complicated task, but one that needs attention and a great deal of attention will be centered on this program during the coming year.

The Committee was instrumental in obtaining additional insurance coverage for the illness of chemical dependency through the Med-Chi insurance program. This was an area long in need of updating.

The American Medical Association requested that this Committee be represented at a National Conference on the Impaired Physician in Minneapolis, MN to present the protocol prepared by the Committee. This proved to be a very well-attended and successful meeting. An invitation has been issued to have the next conference in Baltimore, possibly in 1980.

The Chairman and Vice Chairman of the Committee have appeared on several television programs to explain the purpose of the Committee and its experience. While press coverage has not been actively sought, there has been interest on the part of several writers, and several stories, mostly favorable, have appeared in several newspapers.

A new Subcommittee of this Committee has recently been set up for the purpose of preparing programs for retiring physicians which would provide them financial and professional comfort. One reason many physicians practice longer than their motor and mental skills would indicate is because they have no other interests or abilities. It is hoped that this Committee may develop something that will be of benefit to this group of our colleagues.

The Committee sponsored a three-hour program at the Faculty's Annual Meeting at Hunt Valley, besides sponsoring a booth. While attendance at the program was somewhat disappointing, plans are presently being laid for a more dynamic program at the next Annual Meeting, in a more popular time spot so that more attention may be given to it.

Members of this Committee have devoted many hours and much of their personal energies to this Committee. I wish to express my appreciation to each of them.

Respectfully submitted,
JEROME J. COLLIER, MD, Chairman
JOSEPH CHAMBERS, MD,
Vice Chairman
WOLFE ADLER, MD
JOSEPH I. BERMAN, MD
MRS. CAROL BROADDUS
WILLIAM T. DIXON, MD

JAMES FLYNN, MD
SISTER M. THOMAS
MAXWELL N. WEISMAN, MD
KENNARD L. YAFFE, MD □

EMERGENCY MEDICAL SERVICES

Mr. President and Members of the House of Delegates:

Throughout the year, the Emergency Medical Services Committee has concerned itself with issues pertinent to emergency medical care services provided the general public. As a new year approaches, we shall continue to direct our efforts toward continued improvement in this area and maintain effective liaison with organizations/institutions concerned with such services.

Action of the Committee for the past year is as follows:

1. The Committee devoted considerable discussion to the problem of liability imposed upon emergency physicians when patients are admitted through the emergency room. The main concern is at what point does the emergency physician relinquish responsibility for care of the patient, and at what point is liability terminated. The Faculty's legal counsel has advised that unless the patient's welfare is in jeopardy, the emergency physician should keep the patient in the emergency room until the attending physician has arrived at the hospital to admit the patient, and assume clinical responsibility from that point on. Following lengthy discussion, it was agreed that the patient who leaves the emergency department for an inpatient area after the attending has been notified and has given verbal orders to the nurse, presents a continuing responsibility to the emergency physician, shared with the attending physician, until the actual arrival of the attending physician. Therefore, it is incumbent upon all hospital governing boards, administrations and medical staffs to address the question and arrive at appropriate guidelines for timely arrival of attending physicians. Failure to address this question may create a situation in which deterioration of a patient's condition occurs during an excessive period of absence by the attending physician. Leaving the responsibility entirely with the emergency physician for long periods of time only increases his liability exposure without decreasing that of the hospital or attending physician. It was the consensus of the Committee that during evening and weekend hours, the hospitals' liability would be decreased if coverage by an in-house physician were arranged by contract rotation of the medical staff or other suitable arrangements.

2. In response to a request from the Maryland Institute for Emergency Medical Services, the Committee reviewed and accepted information to be published in Baltimore area phone books concerning the availability of emergency medical services and/or treatment in emergency/

disastrous situations. This was endorsed by the Council and will appear in a forthcoming issue of the white page phone book.

The Chairman would like to thank all members of the Committee for their invaluable assistance and support throughout the year.

Respectfully submitted,
GEORGE M. SIMONS, MD, Chairman
ROBERT T. ADKINS, MD
FRANK T. BARRANCO, MD
PRABIR BOSE, MD
JOSEPH I. BERMAN, MD
VEJAYAN CHARLES, MD
SALVATORE R. DONOHUE, MD
FRANK DREWS, MD
GEORGE E. ENGELKE, MD
MAX R. ENGLISH, MD
GEORGE H. GREENSTEIN, MD
SUSAN GUARNIERI, MD
TIRSO JOSON, MD
ROBERT M. McDONALD, MD
JOHN L. MORGAN, MD
THOMAS J. OGLESBY, MD
JEAN THORNE, MD
BENJAMIN D. WHITE, MD
MCRAE WILLIAMS, MD
ANNE ZEVALLOS, MD
Advisory Members
ELIZABETH HILLIKER, MD
SATISH KHANEJA, MD
CLAUDIUS KLIMT, MD
GEN. WM. U. OGLETREE
DAVID A. PAUL, MD
HENRY S. SABATIER, JR., MD
ROBERT SCOVNER, MD
BERNARD S. SLOSBERG, MD
JOHN D. STAFFORD, MD
STEVEN SUMMER
GARY LANGSTON, MD
DONALD GANN, MD □

ed as a recipient of the award for his pioneering work in the treatment of shock and trauma, the development of emergency medical service systems and his work in thoracic surgery and hyperbaric oxygen therapy.

Director of the nation's first clinical trauma center, Dr. Cowley came to Baltimore following graduation from the University of Utah to enter the University of Maryland School of Medicine. Dr. Cowley ultimately joined the University of Maryland as the founder and head of the first accredited thoracic surgery program on the East Coast.

Dr. Cowley's research into the causes of shock and the treatment of shock and trauma developed into the establishment of a two-bed



DR. COWLEY

Doctors in the News

Dr. Cowley Honored

Dr. R. Adams Cowley, Director of the Maryland Institute for Emergency Medical Services (MIEMS), has been named 1979 Distinguished Alumnus by the University of Utah.

The Distinguished Alumnus Award is the highest honor bestowed by the University of Utah Alumni Association upon a former student. Dr. Cowley is a 1939 graduate of the University.

The award program was initiated in 1958 to recognize those Alumni who have "Served the nation, the University or their profession with distinction." Dr. Cowley was select-

ed as a recipient of the award for his pioneering work in the treatment of shock and trauma, the development of emergency medical service systems and his work in thoracic surgery and hyperbaric oxygen therapy. Director of the nation's first clinical trauma center, Dr. Cowley came to Baltimore following graduation from the University of Utah to enter the University of Maryland School of Medicine. Dr. Cowley ultimately joined the University of Maryland as the founder and head of the first accredited thoracic surgery program on the East Coast.

Dr. Cowley is a pioneer in a number of other surgical and program areas. He was a leader in the development of the first transistorized pacemaker, the first artificial blood

vessel and the first self-contained, self-balancing monitoring system. In addition to establishing the nation's first shock trauma unit, he co-developed the first civilian helicopter program for the transportation of critically injured patients, and advised the US Senate on the formulation of the nation's EMS legislation.

Under Dr. Cowley's leadership, Maryland has continued to lead the nation in the development of emergency medical service systems. Maryland initiated the nation's first multi-state EMS consortium, the Mid-Atlantic EMS Council, to resolve interstate EMS concerns such as reciprocity, transportation and communications compatibility. The Institute hosted the first international symposium on trauma and has implemented the nation's first multi-level trauma referral system and the first comprehensive EMS communications system as well.

Most recently, Dr. Cowley was appointed to President Jimmy Carter's National Highway Safety Advisory Committee, for which he chairs the Subcommittee on Emergency Medical Services.

Hopkins Study Aims to Find Who Needs New Insect Sting Allergy Treatment

An effective new therapy that prevents life-threatening allergic reactions to insect stings has been approved by the Federal Food and Drug Administration. The availability of the treatment offers peace of mind to the one-two million people in the United States thought to have severe insect sting allergies, but it also presents a dilemma to physicians who treat people with these allergies, according to Drs. Martin Valentine and Lawrence Lichtenstein, developers of the treatment.

The therapy, a series of injections of gradually increasing amounts of pure insect venom, has "blocked" the allergic reaction mechanism in 95% of children and adults studied by the Johns Hopkins scientists who developed the therapy. Without the new allergy shots, those people allergic to insect venom

could have experienced sting reactions such as difficulty in breathing, a drop in blood pressure, unconsciousness or even death, but Drs. Lichtenstein and Valentine point out that there is still no good test to predict who is most at risk for such serious allergic reactions and who needs the expensive and potentially lifelong treatment. The scientists are seeking volunteers for two studies they hope will help them determine which people stand to benefit the most from the new therapy.

For the first study, they are seeking people, 18 years of age and older, who were stung in the past year without a reaction or with only minor redness and swelling, to see what percentage of them has become unknowingly allergic. According to the Hopkins scientists, some people who have been sensitized, but suffered no reaction when previously stung might be in danger of suffering a serious reaction the next time they are stung. They hope to discover how many of these unknowingly allergic people will lose their sensitivity to insect venom, how long it takes to lose it and how much of a health risk they face the next time they are stung. To volunteer for this study, call the Allergic Disease Center at (301) 323-2200, ext. 458.

For the second study, the scientists are seeking children between three and 16 years of age who have experienced an allergic reaction in the past. They point out that scientists still don't know whether a person who had an allergic reaction in the past will have a worse, similar or milder reaction if stung again. They are looking at children because many youngsters lose their sensitivity to stings over time, and some get more severe reactions with each sting. Those children who would lose their sensitivity quickly might not need venom therapy. Parents and doctors who would like to refer a child to the study should call the Allergic Disease Center at (301) 323-2200, ext. 394.

According to Drs. Valentine and Lichtenstein, who are co-directing the insect sting studies, there are

three types of reactions to insect stings: most people, when stung by a yellow jacket, honeybee, hornet or wasp, will have a "normal" reaction consisting of pain and swelling at the site of the sting, lasting less than 24 hours. A small number of people will have a "Non-life threatening generalized reaction" to the sting. They may itch all over, break out in hives and swell on the face and the extremities. Most serious is the "life-threatening generalized reaction," which is accompanied by difficulty in breathing, a drop in blood pressure, unconsciousness and, rarely, death. It is people in danger of suffering from the third type of reaction that the Hopkins team hopes to be better able to identify through their latest studies.

Dr. Patz to Head Wilmer Eye Institute at Hopkins

Arnall Patz, MD, the man who eliminated the foremost cause of blindness in children and pioneered the use of the laser to treat certain eye diseases, has been named Director and Ophthalmologist-in-Chief of the Wilmer Ophthalmological Institute of the Johns Hopkins Hospital and Professor and Director of the Department of Ophthalmology at the Johns Hopkins School of Medicine, effective July 1, 1979.

He succeeds Dr. A. Edward Maumenee, one of the nation's most preeminent ophthalmologists and a noted ophthalmic surgeon, who has directed Wilmer for 24 years. Dr. Maumenee will continue on the full-time staff, participating in surgical and teaching programs of the Department of Ophthalmology.

In the 1950s, Dr. Patz found that excess oxygen administered to premature babies in incubators caused a disease called retrolental fibroplasia, then the major cause of blindness in children. For that discovery he received many honors, including the Albert Lasker Award and the Mead-Johnson Award, both in 1956.

In the late 1960s, Dr. Patz and his collaborators from the Hopkins Applied Physics Laboratory pioneered in the development of the

argon laser and in its use to seal hemorrhaging blood vessels in the retina. This condition occurs in a complication of diabetes called diabetic retinopathy. Dr. Patz served as Deputy Chairman of a National Eye Institute-sponsored 16 hospital study that proved the benefits of laser treatment. As a result, the risk of blindness for thousands of diabetic patients has been substantially reduced.

Most recently, Dr. Patz has directed a team of investigators studying the role of substances which may cause growth of abnormal new blood vessels in the eye. Because of the broad impact of his studies, he has been named next recipient of the Friedenwald award, the leading research prize in American ophthalmology. The Award is named for the late Dr. Jonas Friedenwald, a pioneer research scientist at Wilmer in the 1930s and 1940s.

The Wilmer Institute was founded in 1925 and named after its first director, Dr. William H. Wilmer, who retired in 1934. His successor was the late Dr. Alan C. Woods, who served until 1955, when Dr. Maumenee became Chairman. Under their combined leadership, the Wilmer Institute has become an internationally-renowned eye center.

A native of Georgia, Dr. Patz is a graduate of Emory University Medical School. He interned at Sinai Hospital in Baltimore and received residency training in Washington. In 1955, he joined the Hopkins faculty, but continued a private practice in ophthalmology until 1973, when he became a member of the full-time staff. He is a consultant at Maryland General Hospital, Sinai and the Greater Baltimore Medical Center.

Dr. Patz is the Seeling Eye Research Professor at Hopkins and Director of its Diabetic Retinopathy and Retinal Vascular Centers, where ophthalmic scientists from throughout the world have come to study.

His interest in teaching, as well as research, has lead him to develop numerous award-winning films and scientific exhibits, in addition to authoring nearly 140 scientific ar-

ticles, editing scientific journals and writing a textbook, **Protection of Vision in Children.**

He is married to the former Ellen Levy, a cytotechnologist in the Division of Cytopathology at Hopkins Hospital. They have three sons and a daughter.

Hopkins Names Dr. Lee Riley Chairman of Orthopedic Surgery

Lee H. Riley, Jr., MD, a pioneer in developing artificial joints, has been named Chairman of the Department of Orthopedic Surgery at the John Hopkins School of Medicine and Orthopedic Surgeon-in-Charge at the Johns Hopkins Hospital, effective July 1, 1979, when he succeeded **Robert A. Robinson, MD.**

In the late 1950s and early 1960s, Dr. Riley became known for developing, with Dr. Robinson, an approach to operating on the spinal column in the neck that made such operations after and easier to perform. This anterior approach to the cervical spine was particularly important because neck problems—caused by injuries, tumors, infections, arthritis and other diseases—occur so frequently.

In the early 1970s, Dr. Riley was a leading member of a group that developed the first practical, artificial, total-knee joint. This design proved to be the model for several subsequent total-knee replacement devices.

In 1969, Dr. Riley, Dr. Robinson and Dr. **Gerald Finerman** performed one of the first artificial total-hip joint replacements in this country. The artificial hip has given a new lease on life to many arthritics who were in extreme pain and could only move their own hip joints stiffly, if at all.

Dr. Riley "Is clearly a leader in the field of orthopedic surgery, and his name was introduced for our consideration by a majority of the department chairmen and consultants who were contacted, as well as by nearly all the members of the local orthopedic community," said the report of the committee, which voted unanimously to nominate him.

Dr. Riley received his BA and MD degrees from the University of Oklahoma. He served his internship and residency at Johns Hopkins, where he also held a Surgical Research Fellowship in 1958-59. Before joining the Hopkins faculty in 1963, Dr. Riley was Orthopedic Research and Educational Foundation Fellow in Pathology at the Armed Forces Institute of Pathology. He was Chief of Orthopedic Surgery at Perry Point Veterans Administration Hospital and has served as a consultant to the Federal Food and Drug Administration.

Dr. Riley has been active in increasing communications with Russian orthopedists and was a member of the US delegation to the USSR Committee on Health Cooperation in 1974. Born in St. Louis, MO, he is married to Helen Mutch Riley and has two sons.

Dr. Riley succeeded Dr. Robinson, one of the nation's leading authorities on replacement of complete joints and developer of an operation to remove spinal discs. Chairman of the Department since 1953, Dr. Robinson will continue on the full-time staff of the medical school and hospital. In addition to caring for patients, he directs a major research project funded by the National Institute of Arthritis, Metabolism and Digestive Diseases to study the composition of connective tissue. Friends and former students of Dr. Robinson are collecting gifts and pledges to endow a professorship in his name. Almost \$800,000 of the required \$1 million has already been raised.

Research Into Viral Infections During Pregnancy Earns Hopkins Scientist Cerebral Palsy Award

Richard T. Johnson, Eisenhower Professor of Neurology at the Johns Hopkins School of Medicine, has received the United Cerebral Palsy Research and Educational Foundation's Weinstein-Goldenson Award for Medical Research for his work in viral infections which affect the fetal nervous system, causing dis-

orders such as cerebral palsy. The award was presented at the United Cerebral Palsy National Conference in Atlanta recently.

Viral infections during pregnancy may play a far greater role in causing cerebral palsy than previously suspected, according to Dr. Johnson. "We don't know the magnitude of the problem yet, but rubella, the cytomegalovirus and several other infections during pregnancy can have both major and subtle effects on the brain of the developing fetus, causing motor disabilities which are collectively called cerebral palsy," he explains. "We also know that the average woman during pregnancy has multiple viral infections. Some may cause her no more than the symptoms of the common cold, and some may cause no symptoms at all. Whether these infections cause damage to the developing fetus is unknown."

Dr. Johnson has shown that a number of viruses can cause hydrocephalus, that a sheep vaccine virus can cause abnormalities in lambs similar to those commonly found in children with cerebral palsy, that a rat virus in newborn hamsters infects very specific cells preventing the hamsters from developing motor control as they mature and that many viruses can infect the developing inner ear, affecting structures critical to normal movement.

"Our present challenge is to determine whether similar infections in the human fetus or newborn do similar damage. We have already obtained some data indicating that mumps virus may occasionally cause hydrocephalus in children, and we are now devising more sensitive methods to detect mumps and other viruses in children with varied forms of cerebral palsy," Dr. Johnson says.

Dr. Nathans Elected to National Academy of Sciences

The National Academy of Sciences announced recently the election of 60 new members in recognition of their distinguished continuing achievement in original research. Among the outstanding

scientists and engineers so honored were **Daniel Nathans, MD**, Boury Professor and Director of the Department of Microbiology and Manfred Mayer, PhD, professor of microbiology, at The Johns Hopkins University School of Medicine.

The election was held during the business session of the 116th Annual Meeting of the Academy. Election to membership in the Academy is considered to be one of the highest honors than can be accorded an American scientist or engineer.

Dr. Nathans was honored last year as a winner of the 1978 Nobel Prize in medicine or physiology, which he shared with **Hamilton O. Smith, MD**, Professor of Microbiology at Hopkins, and **Werner Arber, MD**, of Basel, Switzerland. The three were chosen for their work with restriction enzymes, the so-called "chemical knives" which have revolutionized molecular biology by enabling researchers to precisely cut DNA, thereby opening up a new era in the study of how DNA, the genetic blueprint, functions.

Dr. Nathans came to Hopkins in 1962 as an Assistant Professor of Microbiology and became Director of the Department in 1972. A native of Wilmington, DE, he received his MD degree in 1956 from Washington School of Medicine in St. Louis, MO.

The National Academy of Sciences is a private organization of scientists and engineers dedicated to the furtherance of science and its use for the general welfare. The Academy was established in 1863 by a Congressional Act of Incorporation signed by President Abraham Lincoln which calls upon the Academy to act as an official advisor to the Federal government upon request in any matter of science or technology.

Germans Honor Russell Morgan, former Hopkins Medical Dean, for Radiology Milestones

Russell H. Morgan, MD, Dean Emeritus of the Johns Hopkins University School of Medicine, received the German Roentgen Medal, given for outstanding ad-

vances in radiology, in Remscheid, Germany recently. Attending the ceremony was the President of the Federal Republic of Germany, Walter Scheel, and his wife, Dr. Mildred Scheel, who is a Radiologist.

Dr. Morgan's perfection of image intensification in radiology improved X-ray images for diagnostic purposes and was considered as significant an advance in the 1960s as CAT scanners have become in the 1970s.

Dr. Morgan was also one of the first radiologists to become actively involved with the problems of radiation safety and the control of radiation hazards as a public health concern. He called early for the epidemiological evaluation of X-ray exposure received by patients in diagnostic tests and authored several books concerned with radiation safety.

In 1958, he recommended that radiation safety standards and health research be centralized in a single agency, and that research focusing on radiation health effects be pursued to establish radiation safety standards. These recommendations were ignored then, but Dr. Morgan continues to emphasize the need to develop an understanding of the relationship between biological effects and radiation dosage. Currently, he is Chairman of a National Academy of Sciences Committee reviewing the health research programs of the Department of Energy.

Dr. Morgan's Hopkins career began in 1946 when he was named Professor and Chairman of the Department of Radiology at the Hopkins School of Medicine and the first Radiologist-in-Chief of the Hopkins Hospital. In 1960, he became Professor and Chairman of the Department of Radiologic Science in the School of Hygiene and Public Health. Named Dean of the School of Medicine in 1971, he became Vice President for the health divisions in 1973—posts he held until 1976.

During the Second World War, he became active in the US Public Health Service in methods of planning and evaluating X-ray film

surveys of large populations, particularly in the application of fluorographic techniques to tuberculosis control programs. This led to a long association between Dr. Morgan and the Bureau of Radiological Health of the US Public Health Service, and to his active participation in the design and application of public health measures in radiological health.

His clinical investigations are currently concerned with diagnosis

and care of people suffering from black lung disease and asbestosis.

Born in London, Ont., Dr. Morgan became a naturalized US citizen in 1943. His undergraduate and medical education was at the University of Western Ontario, from which he received his MD degree in 1937. He taught radiology at the University of Chicago for two years, until 1946, when he left to join the Hopkins faculty. Last spring, the Hopkins School of Medicine named

its Department of Radiology and Radiological Science in his honor.

The medal he received in Germany was presented by the German Roentgen Museum Society and is considered one of the highest honors in radiology. The Society commemorates **Wilhelm Konrad Roengen**, who discovered the X-ray in 1895, for which he was awarded the Nobel Prize in Physics. Remscheid, Germany, is Roentgen's birthplace. □

Medical Miscellany

Sen. Mathias says Federal Government is Not Doing Its Job in Promoting Mental Health Research

US Senator Charles McC. Mathias, Jr. (R-MD) says the Federal government "Has played too small a role, with too little flair" in promoting research in mental health and behavioral sciences.

The Maryland Senator made his remarks in an address to the annual meeting of the Mennonite Mental Health Services Association sponsored by the Brook Lane Psychiatric Center in Hagerstown, MD.

"Despite dramatic advances in understanding and in treating mental illness," Sen Mathias said, "the incidence of mental and emotional problems in the United States continues to rise and we still do not have a mental health care system equal to our problems."

According to the Congressional Research Service, more than 20 million Americans suffer from some form of mental illness, but only four million actually receive treatment.

He noted that "Every year for the past 10 years, the Federal financial commitment to mental health research has remained at about the same level, which, in the times of inflation, is bad news. This has just not been enough to meet our needs. But, recently, for the first time in a long time, I feel some faint stirrings of hope," he added. "The Administration seems to be singing snatches of my tune."

"In February, 1979, Mrs. Carter's testimony before the Senate Subcommittee on Health and Scientific Research of the Human Resources Committee gave a needed boost to the recommendations of the President's Commission on Mental Health. Mrs. Carter highlighted the fact that inflation has taken a big bite out of mental health research funds since 1967 and she made an eloquent appeal for the increased funding for mental health research in the Administration's otherwise lean health budget," Mathias explained.

"I welcome the increase in funds for mental health research and I salute Mrs. Carter for the push she is giving to new mental health initiatives, but I think we have to examine these new initiatives in the context of the total budget for mental health to be sure the Administration isn't 'robbing Peter to pay Paul.' For example, while research funds will be increased, training funds will be cut."

"The 95th Congress last year appropriated \$573,633,000 for mental health programs for Fiscal Year '79. The President has recommended \$534,114,000 for FY '80 and a supplemental request of \$4,118,000 for FY '79. This is a net decrease of \$43,637,000 from the FY '79 level.

"I have been fighting for a long time for adequate funding for mental and physical health programs," Maryland's senior Senator said in conclusion. "I intend to do battle again when the Labor-HEW Subcommittee of the Senate Appropriations Committee meets to consider the President's budget proposals." □

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Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

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4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of the State of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to the Physician Placement Service, 1211 Cathedral St., Baltimore, MD 21201; telephone 1-301-539-0872.

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

Journal announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

Labor and Delivery of a Viable County Auxiliary

As most people know, human gestation takes 40 weeks, however, the gestation period of a county auxiliary is more like that of an elephant and just about as difficult.

Conception took place on March 5, 1977, when I was approached by some of the wives about starting a county auxiliary. Helen Boyer and Carol Broadus met with Irene Banerjee, Fatima Haziq, Nancy Howell and Marlene Kassem in the latter part of April. At that time, they explained the workings of the Auxiliary to Med-Chi and the relationships between the component auxiliaries, the state and the AMA Auxiliary. We were given a sample copy of bylaws that could be adapted for our group as well as a sheet titled, *Organizing a New Auxiliary*. Carol and Helen told us that before forming, we had to get permission from the county medical society. They also gave us a tremendous amount of moral support and encouragement.

Within the next month, we wrote to Dr. Chinmay Banerjee, who was then the President of the Charles County Medical Society, requesting permission to form the Auxiliary. On Aug. 4, 1977, we received a letter congratulating us and pledging the support of the Society.

Our first meeting was held on Oct. 13th with 12 people present. We got pledges of support and it appeared that we had viability; however, we had a threatened abortion at the next meeting on Nov. 8th when only five people showed up. At that time, we decided to suspend meeting until a questionnaire had been sent out to see who was interested and in what areas. We also asked for opinions on when to meet and if they were not interested, why? These were sent out in December, 1977 and only two people responded. Needless to say, we were quite discouraged. Two of us worked over the next few months attending the Winter Board Meeting, the Annual Meeting (with a total of four paid members), and making innumerable phone calls.

After the Annual Meeting, armed with encouragement and a resolve to change things, we had a meeting on May 18th. That meeting produced three stubborn, tenacious people; Jean Dettor, Nancy Howell and Marlene Kassem. We continued to have meetings throughout the summer of '78 planning a course of action for the coming Fall. We also decided to involve ourselves in a project, preferably civic, that would give us exposure in the local papers. Marlene and Nancy took the Basic CPR Course followed 10 days later by the CPR Instructors Course. We did this with the help of the Greater Waldorf Jaycees since we did not have the funds or manpower to do it on our own. (The Jaycees are an excellent group with which to align

your auxiliary. They are very interested in the health care areas, and, with their manpower, small groups have a very good resource base.) Jean saw to the publicity and we started getting calls for classes. We raised \$233 from September, 1978-April, 1979.

In September, 1978, we had a brunch at Jean Dettor's with nine people present. Viable again! We discussed IPAs HMOs, national health, CPR, the Christmas cards and showed our new stationery. Our membership drive seemed successful. Some of us had attended the Semiannual Convention and got ideas and encouragement again from other auxiliaries.

October, however, brought another threatened abortion. The total attendance was two with regrets from one—that's right, the summer trio. We took that meeting time for writing reports and planning. (We also consoled each other quite a bit. Our spirits were really low.) One of the reports went to the medical society, given by Dr. Howell, as the auxiliary had never been invited to attend or address a society meeting. We mentioned the CPR courses and the Christmas cards, hoping to make sales to the physicians. We made two. We again decided to dispense with meetings until January, 1979. Even though discouraged and angry, our tenacity prevailed.

At the medical society's Annual Christmas Party in December, we were asked to speak. I'll never remember what I said since I was in shock over having the Auxiliary recognized, but at the end of the evening, the wife of the society's new President, Noida Joson, came over to ask about the next meeting. Dr. Joson extended an invitation to the Auxiliary President to attend the Society meetings. Viability reigns!

Our January, 1979 meeting had five people present with regrets from two. Dues were paid by four. We made plans for a membership luncheon in March, plans for Doctors' Day, and a theatre party and two of us decided to go to the Winter Board Meeting complete with sample drugs and medical magazines.

February was almost snowed out, but four stalwart members still showed.

March gave us our membership meeting with 10 DUES-PAYING MEMBERS! (We picked up another a few days later for a total of 11.) We planned a family picnic for June since many physicians don't have much time to spend with their families and most all social functions are geared for adults. We felt this was a good way for our group to show its interest in the family. Also that month, we participated, along with the medical society, in the Jaycees' Health Fair. (Next year, this group plans on having a physician and an auxilian on the Health Fair Committee.) Each auxilian gave her husband a red carnation to wear for Doctors'

Day and we further celebrated at a production of *Oklahoma* at the local playhouse.

April saw us finalizing plans for the picnic, discussing legislation, and displaying our centerpieces for the Square Dance to be held at the Annual Convention. We also decided to increase our visability by raffling off a mini-garden at the Square Dance.

Our dreams came true when, on May 4, 1979, we were delivered, at the Convention, a certificate from the State Auxiliary for membership—a 175% increase over the previous year! Our conception, threatened abortions and prolonged, dystocic labor produced the birth of a viable component auxiliary. Now that the delivery is completed, we look forward to the growth and success of our offspring.

While our account may seem like the process was easy, it took many months of a few people working laboriously, making innumerable phone calls, meeting disappointment after disappointment, hurt feelings and much blood, sweat and tears before we succeeded.

Every last ounce of ourselves, or so it seemed at times, that we gave was worth it. It takes hard work and there are no magic formulas to make it any easier. There were times when our spirits faltered, but with the encouragement of the state Auxiliary and members from other county auxiliaries, we met at the different functions, our spirits were renewed and we plunged back in. We took every suggestion, because we didn't know what else to do. Somehow, through all those efforts, questionnaires, phone calls and tears, we made it.

To anyone contemplating the "birth of an auxiliary"—take heart, for the fruits of your labor are worth all the pains. None of us involved in this venture would have ever thought of backing out. It became our cause and our sacrifice for the medical profession. Like a mother's sacrifice for her child, so were our sacrifices to produce a county auxiliary.

MRS. DANIEL M. HOWELL
Charles County



The Library Page

JOSEPH E. JENSEN
Librarian
1211 Cathedral St.
Balto., MD 21201 (301) 539-0872

New Book Titles

Aging

WT 104.3
.C 237a
1978
Cape, Ronald Duncan Thomason
Aging: Its Complex Management.
Hagerstown, MD: Med. Dept., Harper and Row, 1978.

Anesthesia

WO 200.3
.P 895
1978
A Practice of Anaesthesia. 4th ed. Phila., PA, Saunders, 1978.

Breast Diseases

WP 870
.B 821
1978
The Breast. Ed. by H. Stephen Gallagher. St. Louis, MO, Mosby, 1978.

Chemistry, Clinical

QY 90
.E 13b
1978
Eastham, Robert Duncan
Biochemical Values in Clin. Med. 6th ed. Bristol, Wright, 1978.

Clinical Competence

W 21
.G 797c
1978
Green, Robert Castleman, 1922-
The Care and Management of the Sick and Incompetent Physician. Springfield, IL, Thomas, 1978.

Endocrine Glands

WK 100.3
.N 964
1978
Nuclear Medicine: Endocrinology. Phila., PA, Lippincott, 1978.

Eye Diseases

WW 600
.H 236
1978
Handbook of Pediatric Ophthalmology. New York, Grune and Stratton, 1978.

Genetics, Human

ZQZ 50
.M 159m
1978
McKusick, Victor Almon
Mendelian Inheritance in Man. 5th ed. Balti., MD, Johns Hopkins Univ. Pr., 1978.

Headache

WL 342
.L 246m
1978
Lance, James Waldo
Mechanism and Management of Headache. 3d ed. Boston, MA, Butterworth, 1978.

Heart Diseases

WS 290
.K 28h
1978
Keith, John Dow
Heart Disease in Infancy and Childhood. 3d ed. New York, Macmillan, 1978.

Hypnotics and Sedatives

QV 77
.H 744c
1978
Hollister, Leo E.
Clin. Pharmacology of Psychotherapeutic Drugs. New York, Churchill Livingstone, 1978.

Malpractice

W 44
.L 416p
1978
Law, Sylvia A.
Pain and Profit: the Politics of Malpractice. New York, Harper and Row, 1978.

Marine Toxins

WR 17
.F 533a
1978
Fisher, Alexander A.
Atlas of Aquatic Dermatology. New York, Grune and Stratton, 1978.

Measles Virus

QW 168.5
.P 2
.F 841m
1978
Fraser, Kenneth Boyd
Measles Virus and Its Biology. New York, Academic Press, 1978.

Muscles

WE 500.3
.B 315m
1978
Basmajian, John V.
Muscles Alive. 4th ed. Balti., Williams and Wilkins, 1978.

Nervous System Diseases

- WL Merritt, Hiram Houston
100.3 **A Textbook of Neurology.** 6th ed. Phila., PA, Lea and
.M 572t Febiger, 1979.
1979

Neurosurgery

- WL Wise, Burton Louis
368 **Preoperative and Postoperative Care in Neurological**
.W 812p **Surgery.** 2d ed. Springfield, IL, Thomas, 1978.
1978

Physical Examination

- WB Rosenfeld, Isadore
200 **The Complete Med. Exam.** New York, Simon and
.R 813c Schuster, 1978.
1978

Psychophysiology

- WL Hecaen, Henri Hyacinthe Octave
102 **Human Neuropsychology.** New York, Wiley, 1978.
.H 445h
1978

Schizophrenia

- WM **Schizophrenia: Science and Practice.** Ed. by John C.
200.3 Shershow. Cambridge, Harvard Univ. Pr., 1978.
.S 337
1978

Sex Behavior

- WM Trimmer, Eric James
611 **Basic Sexual Med.** London, Heinemann Med. Books,
.T 831b 1978.
1978

Skin Diseases

- WR Stewart, Wm. Donald
100.3 **Dermatology: Diag. and Trtmt.** 4th ed. St. Louis, MO,
.S 852d Mosby, 1978.
1978

Surgery

- WO Rickham, Peter Paul
925 **Neonatal Surgery.** 2d ed. Boston, Butterworth, 1978.
.R 539n
1978

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of May, 1979:

1. Spasmodic Torticollis	14 citations
2. Hypoglycemia and Chronic Renal Failure	21 "
3. Allergy to Spices	15 "
4. CNS Manifestations of Thrombopenia	25 "
5. Vitamin B-12 Deficiency in Infancy	14 "
6. Alcoholism in Europe	65 "
7. Mao Inhibitors of Lithium	12 "
8. Literature Reviews on Stress	36 "
9. Hyponosis in General Practice	25 "
10. Delayed Skin Sensitivity Testing	10 "

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
Assistant Librarian

SEMIANNUAL MEETING DATES

Sept. 12-16, 1979—Royal Sonesta Hotel—New Orleans, LA

The Restaurant Page



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forded by nothing more than a full head of hair. Current helmet-facemask systems provide an extraordinary degree of protection to the head and face, he declares.

"As a result, coaches have developed playing techniques that use the head and helmet as a battering ram in blocking, tackling and butting. Such techniques fail to account for the potential danger of injury to the cervical spine when the head is the primary point of contact in a high-impact situation."

In the five-year period of 1959-63, during which time 820,000

Medical Miscellany

New Helmets Blamed for Increase in Broken Necks in Football Players

Deaths from organized football have declined in recent years, but there has been a marked increase in broken necks resulting in complete paralysis.

The protective helmet-facemask system has effectively-protected the head, and, by so doing, has allowed it to be used as a battering ram in tackling and blocking, thus causing more broken necks.

This is the finding of a study by the National Football Head and Neck Injury Registry, published recently in the *Journal of the AMA (JAMA)*.

The Registry has documented 1,129 serious football injuries, mostly among high school and college players, since 1971. Of these, 550 were broken necks, of which 176 resulted in permanent paralysis from the neck down, says Joseph S. Torg, MD, of the University of Pennsylvania Sports Medicine Center, which handled the tabulation.

During the last 20 years there, has been a decrease in fatal injuries and in serious brain injuries, Dr. Torg declared.

Despite the contact nature of tackle football, the fatality and catastrophic injury rates have remained low, he points out. There are relatively-few serious injuries in relation to the total number of players involved during a given season.

Evolution of protective coverings for the head has occurred during the past 70 years. As recently as 1905, protection was af-

youth played football each year, there were 86 deaths as a direct result of football, the Registry found. During the five-year period of 1971-75, with 1,275,000 players in the games each year, 77 deaths occurred. The deaths had been primarily from head injuries, and the modern helmets reduced the risk of death considerably.

Among high schoolers paralyzed from broken necks, 78% of the injuries occurred when making tackles. At the college level, 73% of those paralyzed by neck injuries were defensive backs, Dr. Torg says.

"On the basis of observations and data offered by our study, we firmly believe that the increase in verified cervical spine injuries and permanent paralysis is due to the implementation of playing techniques that use the top or crown of the helmet as the primary point of contact in a high-impact situation."

The Registry was established in Philadelphia by the National Athletic Trainers Association and the Sports Medicine Center of the University of Pennsylvania. □

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Doctors in the News



DR. JOHN B. UMHAU (left) presents DR. CYRIL G. HARDY with a certificate of honor from "The Society to Shorten Medical Society Meetings."



DR. CAROLYN PINCOCK (right) presents DR. JOHN G. BALL with his Med-Chi 40-Year Certificate.

(Above and Right)

FOUR VIEWS OF THE MARCH 20, 1979 MONTGOMERY COUNTY MEDICAL SOCIETY'S GENERAL MEMBERSHIP MEETING

Dr. J. Roy Guyther Named Doctor of The Year!

J. Roy Guyther, MD, Med-Chi Council Vice Chairman and Mechanicsville, MD family practitioner, has been named "Family Doctor of the Year" for 1979 by Good Housekeeping Magazine in conjunction with the American Academy of Family Physicians.

(Editor's Note: This event will be covered in detail in the Journal's October issue.)



J. ROY GUYTHER, MD
Vice Chairman of the Med-Chi Council
(Photo by Tadder, Balto.)

COMMISSION ON MEDICAL DISCIPLINE

ANNUAL REPORT

June 16, 1978 — June 15, 1979

	Fiscal Year 1979	Fiscal Year 1978
**		
Current Previous		
Revocation	5	5
Suspension	1	1
Probation	2	3
Reprimand	5	1
Forced Resignation	0	1
Emergency Suspension	2	0
Reinstatement	2	2
Denial of Reinstatement	1	1



DR. HARDY (left) listens as **FRANCIS C. MAYLE, JR., MD** responds to the question "What Does Med-Chi do for us?"



DR. HARDY (right) presents **DR. KATHERINE CHAPMAN** with a gift in recognition of her 80th birthday and more than 50 years as a practicing physician.

Not Guilty	0	0
Meetings Scheduled	24	22
Meetings Held	19	14
Formal Hearings	10	7
Informal Hearings	19	14
Cases Under Jurisdiction	234	158
Cases Closed	128	63
Currently Active Cases	106	95
Under Investigation	90	79
Awaiting Formal Hearing	16	9
Commission Surveillance	16	5
Missing Respondents	2	2

*Indicates primary Commission action. In some cases, the primary action is associated with a stay of that action; all such cases also have probation with conditions. See detail below.

Revocation:
Emmett Davis, MD—Professional incom-

petence; violation of conditions of probation resulting from prior revocation with stay.

Karl Namvary, MD—Conviction of a crime involving moral turpitude; stay of revocation, probation with conditions.

Harvey Barry Jacobs, MD—Conviction of a crime involving moral turpitude.

Edward E. Holt, MD—Professional incompetence.

Mohammad Baloch, MD—Professional incompetence; stay of revocation, probation with conditions.

Suspension:

Coral Gordon, MD—Professional incompetence; stay of suspension, probation with conditions.

Probation:

Magin Quiambao, MD—Professional incompetence; conditions.

Martin Buell, MD—Professional and mental incompetence; conditions.

Reprimand:

Lewis B. Newberg, MD—Professional incompetence; probation with conditions.

Anselmo Alliegro, MD—Professional incompetence; probation with conditions.

Artemio Arciaga, MD—Professional incompetence; probation with conditions.

Leonard Flax, MD—Professional incompetence probation with conditions.

Augustin Dordal, MD—Professional incompetence; probation with conditions.

Emergency Suspension (temporary):

Leonard Flax, MD, Martin Buell, MD

Cases Terminated by Death:

Russell Morris, MD, Marvin Saiontz, MD

Denial of Reinstatement:

Emmett Davis, MD

Reinstatement:

Paul Schonfeld, MD, Shim Eung Kim, MD (with probation)

Legislation of Interest to Commission, 1978-79

1. HB 1375 and SB 961—Consumer Representation—In Summer Session

2. HB 741—Identification of Physician Specialists—passed, vetoed by Governor

3. HB 170—Discipline of Physician assistants—withdrawn

4. HB 425—Special Funding, Board of Medical Examiners—In Summer Session

Court Decisions of Interest to Commission—1978-79

1. The Court of Appeals upheld Circuit Court of Special Appeals decisions in favor of enforcement of certain Commission subpoenas.

2. A Commission declaratory ruling on physicians directories was upheld on appeal to the Court of Special Appeals. The Court of Special Appeals decisions in favor and motions for summary judgment to a Federal Court were remanded to the attorneys involved.

Commission Membership, FY 1979

Karl F. Mech, M D

Eli M. Lippman, MD

Jerome J. Collier, MD

Francis Mayle, Jr., MD

John G. Ball, MD

Arthur T. Keefe, MD

Vincent J. Fiocco, MD

Frank M. Shipley, MD

John E. Adams, MD, Chairman

Commission Counsel, FY 1979

General Counsel—Jack C. Tranter, Assistant Attorney General

Administrative Prosecutors:

Constance H. Baker, Assistant Attorney General

Susan K. Ganvey, Assistant Attorney General

Stephen J. Sfekas, Assistant Attorney General

Respectfully Submitted:

John E. Adams, MD
Chairman



Doctors Take Note

Maryland Area: The Free State

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Bldg. unless otherwise indicated. Info: Mrs. Beatrice Parker, Office of Continuing Educ. Johns Hopkins Med. Institutions, Turner 19, 720 Rutland Ave., Balto., MD 21205, phone (301) 955-3166.

Sept. 6-7, Diag. Ultrasound in Ob/Gyn.; for details, call (301) 955-5880.

Sept. 28-29, Current Drug Use in Pregnancy Postgrad. Conf. For details, call Dr. Janet Hardy, (301) 955-6046.

Oct. 11-13, Topics in Gastroenterology and Liver Diseases: Med. and Surg. Aspects. For details, call Dr. Janet Hardy at (301) 955-6046.

Oct. 3-5, Adolescent Pregnancy: Management and Prevention, An Investment in Futures. For details, call (301) 955-5880.

Taylor Manor Hospital

For details, contact Frank J. Ayd, Jr., MD, Taylor Manor Hosp., Ellicott City, MD 21043, or call (301) 465-3322.

Sept. 19, Depression and Pseudo-Dementia, talk by Paul McHugh, MD, Henry Phipps Professor of Psychiatry, JHU Sch. of Med.

University of Maryland

Sept. 18, Current Concepts in Diag. and Trtmt. of Retinal and External Ocular Disease. Balto., campus. For details, call (301) 528-3956.

Sept. 27-28, The High-Risk Infant: Who are They and What

Happens to Them? Univ. Med. Campus. For further info. contact the Prog. of Cont. Educ. at (301) 528-3956.

Sept. 27-Nov. 1; Selected Topics in Family Prac., Part 1, (Thurs., 5:15-7:45 P.M.) Univ. Med. campus. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 5, Nutrition, College Park Campus Adult Educ. Ctr. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 10-12, Computer Tomography Symp.: Body CT and Neuroradiology, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 26-27, Practical Clin. Endocrinology, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Other Maryland Meetings

Sept. 20-23, Contemp. Surgery: Univ. Ctr. or Community Hosp. by Fallston Genl. Hosp., Sheraton-Fontainebleau, Ocean City, MD. For details, call Nancy Miller at (301) 879-0500, ex. 3160.

Sept. 28-30, Cardiac Symptoms, Arrhythmias and Holter Monitoring, Arlington Hyatt, Wash., DC. For details, call (800) 525-8646.

Miscellaneous Meetings

Sept. 14-16, AMA Regional CME Mtg., Williamsburg, VA, 13 Cat. 1 courses: Basic Life Support—CPR; Common Neurological Problems; Acid-Base, Fluid and Electrolyte Balance; Office Dermatology; Basic Electrocardiography, Advanced Cardiac Life Support—CPR, Human Sexuality: Genesis and Therapy of Sexual Dysfunctions, Office Orthopedics, Office Gynecology and Endocrine Problems, Allergy and Immunology, Office Pulmonary Function Testing and Chronic Obstructive Lung Disease, Modern Management of Congestive Heart Failure, Physician's Practice Management—Managing the Business Side. For details, call Lloyd W. Prang, AMA, (312) 751-6000.

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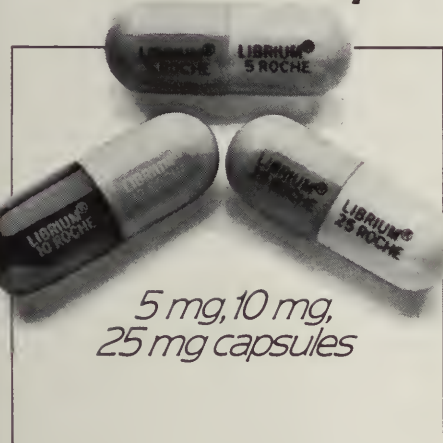
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The author (center), Professor Huang Chia-ssu, MD, President of the Chinese Academy of Medicine at Peking, is flanked by Baltimore City Medical Society Treasurer Dr. Kennard Yaffe (left) and President Albert M. Antlitz, MD (right.) Photo by Bernadette Lane, BCMS Executive Director.

Special Article:

Medicine in the People's Republic of China

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Physicians. Isn't It Time Your Career Had A Check-Up?

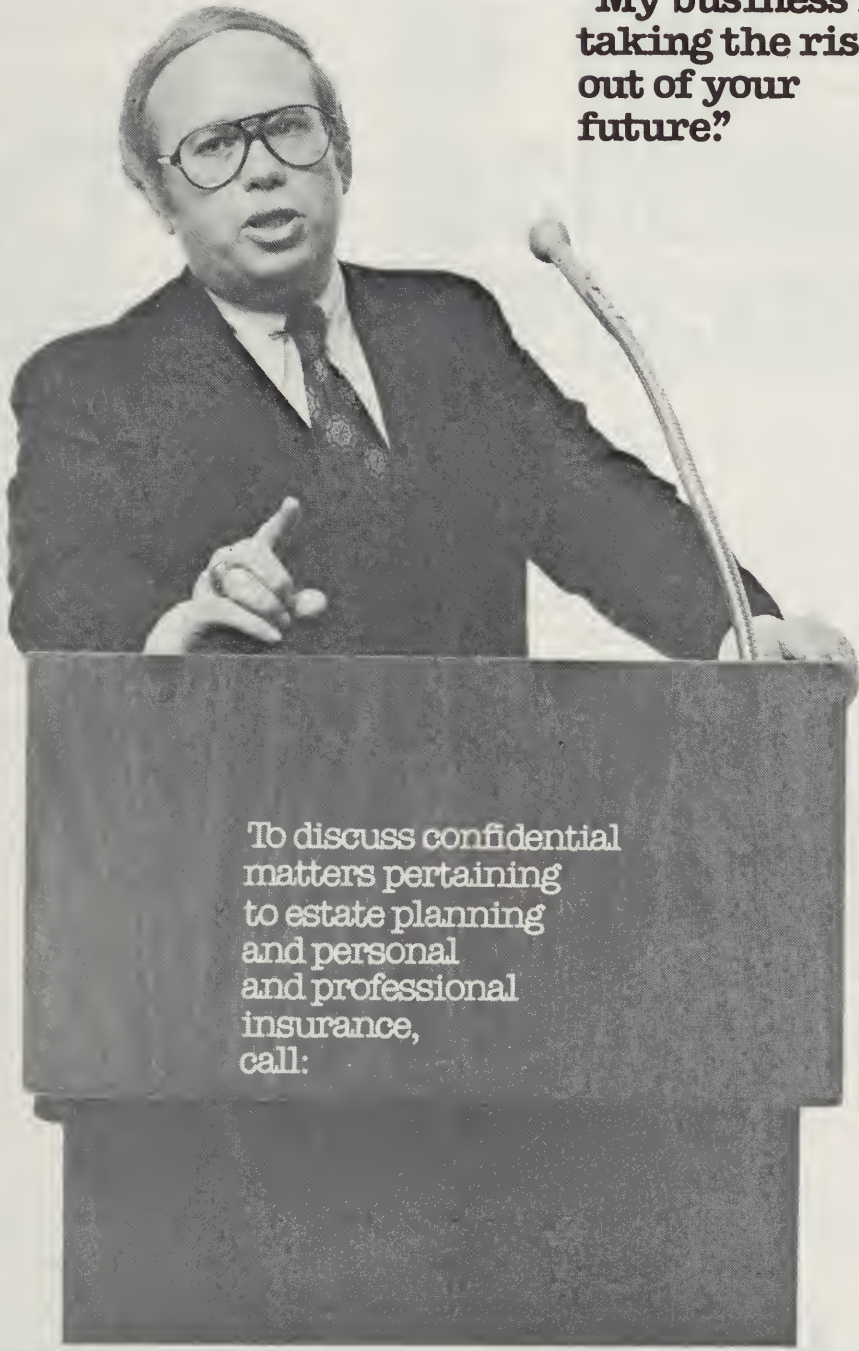


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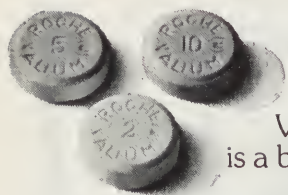
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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EDITORIAL and BUSINESS OFFICE:
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Class postage paid at Baltimore, MD.
Accepted at the special rate au-
thorized. Published monthly.
Subscription rates: US, US Pos-
sessions, one year \$8; elsewhere
\$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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(Photo by Judy Buck, 1977.)

THE COVER: Photo by BCMS Executive Director Bernadette Lane; Chinese flag artwork by Claude Brooks, Baltimore.

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The Open Forum

Heart Attack! A Challenge to the JOURNAL

Two articles recently printed in the *Journal of the American Medical Association* (JAMA) dealt with the first response to severe chest pain. In the Aug. 4, 1978 issue of JAMA, an editorial read as follows:

"Ask a sedentary American who is well into middle-age whether he has any growing fears regarding his health and he will probably tell you he worries about having a heart attack."

Yet the average American's first response to severe chest pain is to try to come up with reasons why it can't be anything serious. Anxiety and defense response (such as intellectualization, rationalization, displacement and denial) are responsible for many patients' delays in seeking medical attention. Since most deaths occur within the first two hours after the onset of symptoms, this delay can be fatal.

According to Thomas P. Hackett, MD, Chief of Psychiatry at Massachusetts General Hospital, this anxious response occurs regardless of the patient's level of sophistication or education. At the American Psychiatry meeting, Dr. Hackett reported the results of studies of anxiety in Myocardial infarction. Several cardiologists were subjects in the study" and even they usually deny the significance of their chest pain" and they too waited before contacting another physician and/or going to the Emergency Room, reported Dr. Hackett.

Hence, the question arises how can Health Professionals get the public to reduce delay time? Dr. Hackett said that the answer is to *Frankly publicize the fact that a typical first response to chest pain is the denial that it may be a heart attack.* As an example, many people take antacids in an effort to see if the pain is indigestion and wait to see if it will go away. What is equally as important is continual reassurance that thousands of people return to fulfilling lives after myocardial infarction. The ideal behavior when experiencing severe chest pain would be to go to the hospital immediately, most people, however, do not. Usually they wait a few hours until their anxiety, and not the pain, has built to an intolerable level, and at that point they seek prompt medical attention. Dr. Hackett additionally noted that having a heart attack in the presence of an "Executive spouse" that is, someone who will call an ambulance immediately after the patient complains of chest pain "without asking if the patient wants this done" is the next best thing to the patient himself/herself actually seeking medical help.

A second article in JAMA, published Aug. 25, 1978, presented the results of a poll taken regarding public belief of the cause and prevention of heart attacks. "Our survey has shown a continuing extensive lack of information in the general adult population about the problems causing Coronary Artery Disease." The poll indicated that 41% of college graduates did not name any of the three major risk factors, and that only one percent named all three." Moreover, although three-quarters of the respondents believe that heart attack can be prevented in persons younger than 60 years of age, few could name specific behaviors, (except for stopping cigarette smoking) that would effectively reduce the risk factors.

A criticism sometimes leveled at public educational efforts is that while they may change knowledge, *such programs do not change behavior.* This is, however, not necessarily true; in fact, programs directed at whole communities through the mass media may be effective in reducing the prevalence of risk factors for cardiovascular disease.

Both of these articles highlight the problems about heart attack and shed light on the reasons why 600,000 people die each year from this dreaded disease. The reasons as indicated in these articles are 1) Lack of information 2) Defense mechanisms employed by the patient that lead to procrastination and denial and 3) The need for an "Executive spouse" or knowledgeable member of the family who can take charge. The public has a right to be kept informed regarding the latest information in the field of Coronary Artery Disease. The mass media has an obligation to offer to communities the opportunity to gain knowledge in The Early Warning Signs and the simple techniques of Cardiopulmonary Resuscitation and let's hope that such programs do, in fact, change behavior. Such awareness will then, hopefully, lead to prevention of heart attack. Knowledge regarding the three big risk factors, namely, hypertension, cigarette smoking and a high cholesterol level is imperative. The importance of physical fitness and the benefits of exercise programs is also an important consideration in dealing with myocardial infarction and recovery.

Armed with this information I challenge you to provide the readers of your fine paper with some Life-Saving Information, And I pray that our joint endeavor will serve to save lives and create a healthier lifestyle.

RAYMOND D. BAHR, MD, FACP
Director, Coronary Care System
St. Agnes Hospital
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WHAT DO YOU THINK OF THE JOURNAL?
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(Ed. Note: The JOURNAL accepts Dr. Bahr's challenge with the special section beginning on p. 73 in this issue.) □



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George V. Eltgroth is a Patent Attorney for General Electric. He is legally blind.

George Eltgroth's official title is Counsel for Patent Strategy and Utilization. His work for the International Division of GE involves finding people who infringe on GE patents and handling cross-licensing agreements between major corporations.

Eltgroth is 62. When he was 33, he contracted polio. It took him two years before he was able to walk with a cane. At 41 his vision dropped below the level of legal blindness. But, as Eltgroth points out, "There wasn't anyone who was going to look after me. I had four small children. I had to continue my career." In 1964, Eltgroth negotiated one quarter of GE's acquisition of Compagnie des Machines Bulle from Olivetti. He was put in

charge of patent operations in Phoenix, Milan, and Paris. "I had 20 French lawyers working for me," says Eltgroth, "only two of whom spoke English. So I learned French, not from books, but by ear." Eltgroth is also fluent in German and is able to work in Spanish as well.

"Handling forms is hard for me," says Eltgroth. "I have only peripheral vision about 1 or 2 percent of normal. I read slowly, so I have to do a lot of preparatory work for patent negotiations. My handwriting is weak, so I type. I have physical problems, but by developing my abilities in law and technology, I'm able to make the balance come out positive. I've wrapped up negotiations that would have taken most non-handicapped people five years

in two. When you're handicapped, you've got to test your limits. As a result of my polio, falling is dangerous—ice and snow are a problem. So I put screws in the bottom of my galoshes. When I had crutches, I put hooks on them for my briefcase. You shouldn't dwell on what's lost, but on what you have left."

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Maryland State Department of Health and Mental Hygiene

CHARLES R. BUCK, JR., ScD, Secretary

The Future of Psychiatric Leadership in Maryland's Mental Hygiene Programs?

By GARY W. NYMAN, MD with the Hon. State Sen. ROSALIE S. ABRAMS,
JOHN HAMILTON, MD; STANLEY PLATMAN, MD and CHESTER SCHMIDT, MD

For reprint and other data, contact Dr. Nyman, Director of the Mental Hygiene Administration of the State Department of Health and Mental Hygiene, 201 W. Preston St., Balto., MD 21201.

Introduction

During the last 10 years, Maryland has experienced transient leadership in its Mental Hygiene Administration. Many factors contributed to the inability to attract and keep competent psychiatric leadership in the public sector. This inconsistent and transient leadership had focused increasing concern among psychiatrists in Maryland's private and university sectors about the direction within Mental Hygiene in Maryland. With explicit encouragement and support from psychiatrists in the private and university sectors, a local, academically-oriented, young, clinical psychiatrist accepted the senior mental hygiene professional job in 1976.

In the first year of rebuilding, it became apparent that most psychiatric resources in Maryland were within the private and university sectors. Despite some support and interest, most psychiatrists within the Maryland Psychiatric Society, and within the Johns Hopkins University and the University of Maryland, had only a peripheral awareness of and involvement in psychiatric care in the public sector. During this year, repeated requests were made by many of these psychiatrists for a greater understanding of and involvement in the public sector psychiatry. This interest crystallized the Maryland Psychiatric Society Program Committee's approach to Mental Hygiene leadership for collaboration in preparing the program for the 1976 Maryland Psychiatric Society dinner/presentation.

Discussion evolved over the summer of 1976 as the program took shape. A brief presentation of the issues surrounding psychiatrists' involvement and psychiatric treatment in the public sector by the Director of Mental Hygiene was planned after dinner. It was to be followed with a panel discussion involving a State Senator, a senior public psychiatric administrator, a senior psychiatric hospital administrator and clinician and a senior academic hospital psychiatrist and private practitioner. Ample time for audience commentary and discussion was allotted in the program, as advanced dinner reservations indicated a large audience planning to attend.

What follows is a presentation of the paper, the panel discussion and the audience commentary as it reflects the interest and direction of the interface between public and private/university sector psychiatry in Maryland.

Presentation by Dr. Gary W. Nyman

(Director, Mental Hygiene Administration and Assistant Professor of Psychiatry—Part-time—at The Johns Hopkins University and Clinical Assistant Professor of Psychiatry at The University of Maryland.)

Historically, the discipline of psychiatry provided the essential leadership within the Mental Hygiene System in Maryland. The mentally-ill, the mentally-retarded, the elderly, the poor and

the chronically-infirm were housed together within large State hospitals: Eastern Shore, Crownsville, Spring Grove and Springfield. For many of these patients, treatment was neither available nor feasible and the hospitals assumed the role of custodial care providers. Psychiatrists assumed the responsibility for the care of their patients in their work as Superintendents, Clinical Directors, Division Chiefs, Unit Directors and attending physicians. With increases in resources and treatment alternatives, psychiatry has continued to lead the treatment team in mental hygiene as it focuses on improving the care that patients within State programs receive.

In general, psychiatry in the university and private sectors developed independently from Maryland's State psychiatric programs. Three outstanding training programs at the Johns Hopkins University, the Sheppard and Enoch Pratt Hospital and the University of Maryland Institute for Psychiatry and Human Behavior continue to develop psychiatric expertise within the state. The proximity of two psychoanalytic institutes and the National Institutes of Mental Health has added to the richness of the Maryland psychiatric community. An increasing number of psychiatric beds at hospitals like Peninsula General, Franklin Square, North Charles, Sacred Heart and St. Joseph's have added to the private psychiatric hospital bed space at Brook Lane, Chestnut Lodge, Gundry and Taylor Manor. The non-public psychiatric resources in Maryland continue to grow, consistent with the increasing awareness of a need for this kind of patient care within Maryland and across the country.

During the last decade, the psychiatric community in Maryland (and the United States) has found itself under greater pressures and increasing scrutiny. Many of these pressures have come from organizations *outside* the psychiatric profession. Regional health system agencies and the State Health Planning and Development Agency now review the number of psychiatric beds proposed. The Health Services Cost Review Commission now reviews the charges for inpatient care. Third-party reimbursers now review all psychiatric treatments and make explicit what they will and will not pay for. Non-medical professional organizations have made the competence of other mental health professionals both public and acceptable as adjuncts and/or alternatives to many types of psychiatric treatments. Federal legislation has passed to limit the number of Foreign Medical Graduates in this country and effectively decrease future psychiatric resources for the entire country, especially in the public sector, and our society as a whole has become more psychologically aware, with increasing curiosity and demands on the psychiatric profession for answers to mental health.

Some very intense pressures have come from *within* the psychiatric profession as psychiatrists increasingly reexamine their roles and functions. One major pressure has come from the conflict of psychiatry as either a social or a medical profession. The psychoanalytic and community mental health movements have both served to pull many psychiatrists beyond the medical model to a greater awareness of the patient as a person with interpersonal, family, social and environmental struggles. Technological and pharmacological advances have simultaneously expanded the

medical role of a psychiatrist as a physician caring for the psychiatrically-ill. The pressure on psychiatrists to respond to both ends of the continuum is intense in Maryland. The realization that the three psychiatric training institutions span the entire biophysiological-social spectrum despite their geographical proximity (all within eight miles of each other) is one example of this unresolved, ongoing conflict.

The pressures on psychiatry in the public sector in Maryland are no fewer than in the private and university sectors. Issues of leadership, role and treatment have all been raised and are being intensively struggled with at the present time.

Psychiatric leadership has and is clearly being challenged within Mental Hygiene in the State of Maryland. State laws and regulations have been changed to explicitly dictate the appropriateness and inappropriateness of specific psychiatric treatments. The legal profession has increasingly infringed upon clinical decision-making. Mental Hygiene has been merged with Health into the Department of Health and Mental Hygiene. The benefits of rejoining psychiatry and health in the public sector have cost mental hygiene its autonomy. Psychiatrists and physicians are no longer required to be Secretary of Health and Mental Hygiene, Assistant Secretary for Mental Health and Addictions, Deputy Director of Mental Hygiene, Assistant Directors of Mental Hygiene or Superintendents, Division Directors and Unit Directors for our psychiatric programs. In an era of malpractice conflicts, State psychiatrists and physicians remain without malpractice coverage, an omission of puzzling implications.

The uncertainty about psychiatrists' leadership and role are greatest in Maryland's community mental health programs. Our more than 60 community mental health programs are almost all under operational responsibility of local health departments. The overwhelming majority of these programs are under the leadership of non-medical mental health professionals: psychologists, psychiatric social workers and administrators. The role of the psychiatrist in many of these programs is often less than one-half time as a diagnostic or therapeutic supervisor. It is often reduced to brief psychiatric consultation for medication of patients in aftercare programs. Diagnostic and therapeutic skills often go underutilized for a variety of logistical, philosophical, cultural and/or economical reasons.

The situation in our public psychiatric hospitals has no fewer stresses for psychiatrists. The recognition of differing patient populations and their differing treatment needs has completely shaken the administrative and treatment structure of these facilities. Rosewood has become a facility for the mentally-retarded, with no administrative or treatment ties to Mental Hygiene. Tawes and Bland-Bryant, two buildings on the Spring Grove campus, have become licensed as nursing homes and are no longer part of Mental Hygiene programming and administration. The Alcoholism Units within each psychiatric hospital are being re-focused to prepare for their possible separation from Mental Hygiene. One-day census data highlights that less than half of these State hospital psychiatric patients are really in need of inpatient psychiatric care, a fact that is consistent with reports across the country; yet, where else can they go? Administratively, a multi-purpose facility concept has been proposed to replace the Superintendent-State Hospital model. It is being utilized at the Walter P. Carter Center and the Thomas B. Finan Center. It allows for administrative and non-psychiatric patient care responsibility under non-psychiatric leadership. The resulting lines of authority and responsibility are much more complex and uncertain, with sharing of previously psychiatric leadership with non-psychiatrically trained personnel. The aim is to provide better psychiatric care to the fewer "psychiatric" patients, better non-psychiatric care to the non-psychiatric patients and better support services in areas of administrative services. *Will it work?* Will psychiatric leadership continue in the face of decreased authority for non-psychiatric and support services? Who will wind up really running the programs? Most of all, will it serve to improve the care patients really receive?

Two facts are important to keep in mind as the pressures grow:

1. Psychiatric patients continue to populate Maryland and the U.S. The continued incidence and probable increasing prevalence of psychiatric illness remains. Most moderately to severely-ill psychiatric patients remain either in inpatient acute/chronic psychiatric State hospital programs or in a variety of outpatient

community programs. As yet, we have cured very few despite the reduction of our inpatient census and the increase in the ambulatory impaired.

2. Smaller psychiatric State facilities continue to be built in Maryland. These smaller units, with more modern beds closer to their community population centers, are needed to meet patient needs. The Carter Center, the Finan Center, the Regional Institutes for Children and Adolescents in Baltimore City and Montgomery County, and the Upper Shore Comprehensive Mental Health Center have all been planned to complement services at Maryland's larger regional State facilities. The State is heavily invested in the care of its psychiatric patients in the public sector, a responsibility that seems likely to remain one for the State to meet.

Despite the large number of psychiatric patients in the public sector, and the wealth of psychiatric expertise in the private and university sectors, the interface between the two has not been optimal. The potential for collaboration and integration has been documented by the American Psychiatric Association Consultation and Evaluation Board Study and affirmed in private discussions with members of the Maryland Psychiatric Society from the private, public and university sectors.

It is important to examine three specific areas of potential collaboration:

1. Should more *senior* psychiatrists in Maryland become involved in State hospital and community programs in roles as part-time attending psychiatrists, consultants and/or supervisors?

2. Should more *younger* psychiatrists in Maryland become involved in State hospital and community programs in:

- a) Clinical roles i.e., full-time psychiatrists; i.e., 1/2-time psychiatrists; i.e., part-time psychiatrists with special functions involving psychiatric emergencies, evaluations, treatment planning, treatment, medications, etc.?

- b) Administrative Leadership Roles

3. Should psychiatric *residency* training in the public sector (State) be

- a) Integrated with JHU/Sheppard/Univ. of MD i.e., Carter Center, Springfield?

- b) Broadened to include community and specialized services, i.e., Carter Center Perkins?

- c) Phased out

Psychiatry will only continue to provide leadership in Mental Hygiene in Maryland with more and stronger support from the Maryland psychiatric community. If psychiatrists are not to continue in their historic leadership roles in the administration and organization of public and non-public service systems, then what roles should remain for the psychiatrist to function in? The kind of focus and support that the Maryland Psychiatric Society gives to these questions and to Mental Hygiene in Maryland will be crucial, as the pressures and conflicts continue. . .

Panel Discussion:

The Hon. State Sen. Rosalie Abrams (D.)

The Senator's remarks focused on increasing governmental regulation of the entire health care community. Specifically, measures have recently been aimed at cost containment and greater organization of health care delivery. The legal profession has amplified issues concerning human rights in the public sector and recent court decisions have begun to clarify issues involving patients' rights to treatment. The Humane Practices Commission in Maryland, which Sen. Abrams chairs, has helped to highlight some of the deficits within the public sector care delivery system and has explicitly encouraged greater collaboration between the State and University programs for the benefit of patients and physicians-in-training. Her concluding statements encouraged the Maryland Psychiatric Society to be as active as possible in providing psychiatric leadership in the public sector, to prevent decisions being made without their input and expertise.

John Hamilton, MD

(Superintendent, Spring Grove State Hospital)

Dr. Hamilton expressed concern about the two-tract system of care for psychiatric patients in the U.S. He delineated the tract for the public sector, which cares for the chronically-ill, the

physically-unattractive and the minority group members who are inarticulate about their needs. The care in the public sector has far fewer resources available to it and is less humane. As yet, there is no commitment to make a one-tract system for psychiatric care in the US as there has been for treatment of other medical illnesses. An example of the disparity within the medical and psychiatric systems involves the differences in resources allocated for treatment of acute coronary illnesses and acute psychotic illnesses. Until the psychiatric and health care communities address themselves to a one-tract system of care for psychiatric illness, the public sector will continue to be underserved, underfunded, less effective and less humane than is appropriate and potentially-possible.

Stanley Platman, MD

(Assistant Secretary for Mental Health and Addictions; Associate Professor of the Department of Mental Hygiene, the School of Hygiene and Public Health, the Johns Hopkins University and Clinical Professor of Psychiatry at The University of Maryland School of Medicine.)

Dr. Platman noted Dr. Nyman's focus on psychiatry's authority and Sen. Abrams' and Dr. Hamilton's focus on the challenges facing and responsibilities of psychiatry. His recent review of the Presidential papers of the American Psychiatric Association revealed a frequent historic repetition of today's panel and its concerns. The APA founded by psychiatrists in the public sector, has evolved under leadership of the private and university sectors. With this shift, have some concerns for the responsibilities within the public sector been lost? Twenty years ago, Dr. Harry Solomon, in his Presidential paper, voiced very similar concerns about public sector psychiatry.

Dr. Platman responded explicitly to the three specific areas of potential collaboration. He supported the involvement of more senior psychiatrists in the public sector care delivery system, especially on a consulting basis. He supported the involvement of more younger psychiatrists in the public sector full-time, to allow them the authority for programmatic input that cannot occur from only a *part-time* commitment. He agreed with the non-viability of free standing State residency training programs and the necessity of integrating them with the university and private sectors to provide quality training and care to their patients. He explicitly encouraged the integration aspects of private and university sector psychiatry with the public sector to improve the quality of care for psychiatric patients in our communities.

Chester Schmidt, MD

(Chief of the Department of Psychiatry at Baltimore City Hospitals; President of the Chesapeake Physicians, PA and Associate Professor of Psychiatry and the Johns Hopkins University School of Medicine.)

Dr. Schmidt expressed his agreement with the preceding panelists. As a psychiatrist in both the private and academic sectors, he levied criticism at himself and his colleagues for an abdication of psychiatric leadership in the treatment of the severely-mentally-ill. He commented on the vulnerability of medical leadership in psychiatry to further deprofessionalization and on the potential resolution of the identity of psychiatry with a renewed focus in the treatment of the severely-mentally-ill. The time for reinvestment in the needs of patients in the public sector has arrived and with it has come the need for utilization of those special skills that psychiatrists have as physicians.

Audience Commentary/Discussion

The audience participation was complex, varied and intense. Over 20 professionals chose to comment during a 40-minute period of time. Comments came from psychiatrists in private practice, in the public sector, holding academic positions and with child, adolescent, forensic and psychoanalytic interests. Two comments were made by non-psychiatrists and fit into the general themes of the entire commentary/discussion.

Many of those who expressed themselves were eloquently-summarized by one who said, "Philosophy follows funding (Cohen's Law)." Complaints about inadequately-funded programs, poor salaries, non-reimbursement of malpractice insur-

ance and increasing governmental regulation constraints were expressed. These complaints contributed to what one psychiatrist labeled as the two-tract system, with psychiatric care in the public sector suffering on the lower tract.

Responses also included the realities of these constraints as increasing in the future and as necessary to be worked within and/or effectively-changed. Administrative changes in the public sector of mental hygiene, that decreased the explicit authority of psychiatrists, were noted to be due to the recent vacuum and absence of psychiatric leadership that had existed. Voices were also raised about working to develop a one-tract system and the need for participation of private and university psychiatrists within the public sector.

A startling element of the discussion that continued to the end was its intensity. The comments and responses contained an energy and sense of personal commitment that kept the attention of the audience at a continually-high level. There was real concern about the future of psychiatry in the public sector and about the need for psychiatrists to become more involved in contributing to and shaping the destiny of mental hygiene in Maryland. This concern remains and facilitates the Mental Hygiene Administration's gradually increasing involvement of private and university sector psychiatrists into the public sector in Maryland.

Summary

The 1977 Annual Dinner Meeting of the Maryland Psychiatric Society focused on the relationship between the Maryland psychiatric community and the State's Mental Hygiene Administration. The very large turnout for the dinner, the presentation, the panel discussion and the audience commentary revealed intense interest in expanding collaboration among Maryland's public, private and university psychiatric sectors. Issues involving the politics, the capabilities and the economics of psychiatric consultation, staffing and residency training within the State's programs were explicitly and frankly-explored. Underlying this discussion was a renewing interest of psychiatric leadership for public Mental Hygiene programs in Maryland.

Acknowledgments

The authors would like to express their appreciation to Dr. Clarence Schulz and members of the Maryland Psychiatric Society Program Committee for their help with this program. In addition, we also thank Dr. Lex Smith, Past President of the Maryland Psychiatric Society, for his support and moderation of the entire program and discussion. □

DOCTORS TAKE NOTE:

Oct. 3-5, Management and Prevention of Adolescent Pregnancy: An Investment in Futures, sponsored by and at the Johns Hopkins Med. Insts., Turner Aud. For details, call Elaine Freeman at (301) 955-6680.

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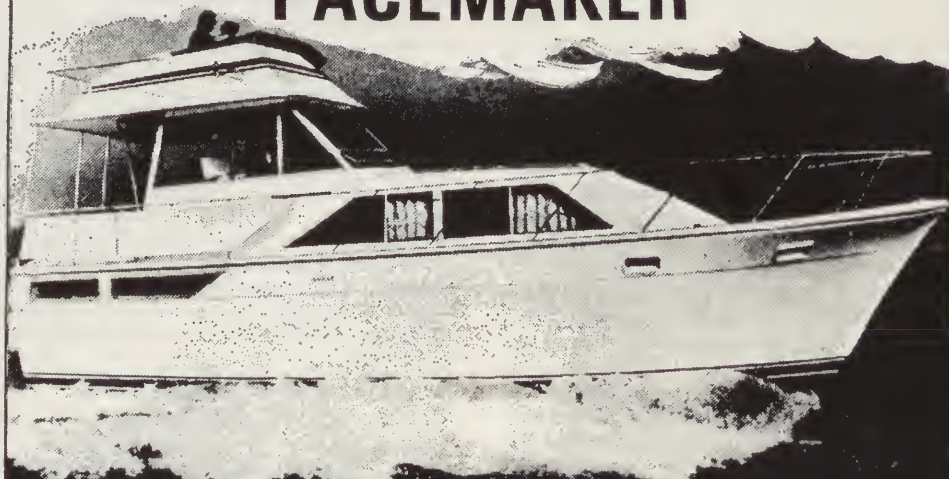
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Executive Director's Newsletter

September, 1979

PRESCRIPTION

The Maryland Board of Pharmacy has received a number of complaints concerning illegibly written prescriptions. Unclear instructions may cause improper labeling and ultimate potential harm to the patient. The Faculty's Committee on Drugs has also encountered similar problems. Physicians are requested to use extreme care in writing prescriptions.

LEGIBILITY

PRIMARY

A research project is currently underway to provide accurate statistical data on primary care physicians in the Baltimore City area. A questionnaire is to be mailed to all physicians in Baltimore City to determine the amount of primary care delivered in their offices.

PHYSICIAN

SURVEY

Any inquiries on the survey questionnaire should be directed to the Baltimore City Medical Society which is a cosponsor of the survey. This survey also has the endorsement of the Faculty.

All names will be removed from questionnaires and individual physicians will not be identified.

ABORTION

INFORMATION

LAW

A law passed in the 1979 General Assembly requires physicians to inform patients about financial and other resources available for carrying the pregnancy to term, for raising the child, and adoption facilities before performing abortion. The patient seeking an abortion must sign a document to be part of the medical record indicating that such information has been received. Failure to notify the patient constitutes a misdemeanor.

The Department of Health and Mental Hygiene and the Social Services Administration have developed the necessary information packets and have distributed them to abortion clinics and hospitals. Individual physicians wishing to obtain information packets should contact the Social Services Administration at 383-3614.

REPORT

ON

HMOs

The Faculty's Ad Hoc Committee on HMOs will make a report to the Council when it meets on Saturday, September 29, 1979. If adopted, the report will be available through the Faculty office.

The ad hoc committee was formed to review local HMO operations and to make recommendations, if any, for correction of any abuses that may be taking place.

NEW
SUBCOMMITTEE -
"60 PLUS CLUB"

A new subcommittee of the Physicians' Rehabilitation Committee has been formed—the "60 Plus Club." The short term purpose is to initiate financial, social and recreational retirement programs for physicians, the objective being to offset the stresses which are peculiar to the profession which could affect the physician's practice, as well as his personal life in later years. The long term goal is the education of young physicians, stressing the importance of developing interests outside the profession.

The first and foremost purpose is to set up a "job bank" for physicians who wish to retire from active practice, yet continue some responsibilities within medicine, or for physicians who wish to gradually diminish their active practice, but remain busy with additional duties of another nature. Spouses of members will be invited to join as well.

Any physician interested in assisting should call either Mrs. Constance Townsend in the Faculty office, 539-0872, or Lester Kolman, MD, at 358-6252.

AMPHETAMINE
REGULATIONS
AMENDED

The State Amphetamine Regulations, restricting the prescribing of amphetamines, have recently been slightly amended. Copies of the new regulations will soon be forwarded to you from the Department of Health and Mental Hygiene, and they will be published in the Journal at a later date. In the meantime, copies will be available in the Faculty office.

SEMIANNUAL
SESSION

The Faculty's Semiannual business meeting will be held on Saturday, September 29, 1979, at 2 PM at the Faculty Building.

The official call to the meeting has been sent to all those involved, including component society officials and executives.

Members may obtain a copy of the agenda through the Faculty office.

LAWS, RULES
AND

A newly revised issue, effective August, 1979, of Laws, Rules and Regulations/Compendium of Faculty Decisions, is available through the Faculty office.

REGULATIONS

The 1979 Handbook is also available through the Faculty office. This booklet contains a listing of Faculty officials, Faculty committees, and officers of the component and statewide specialty societies.


Executive Director

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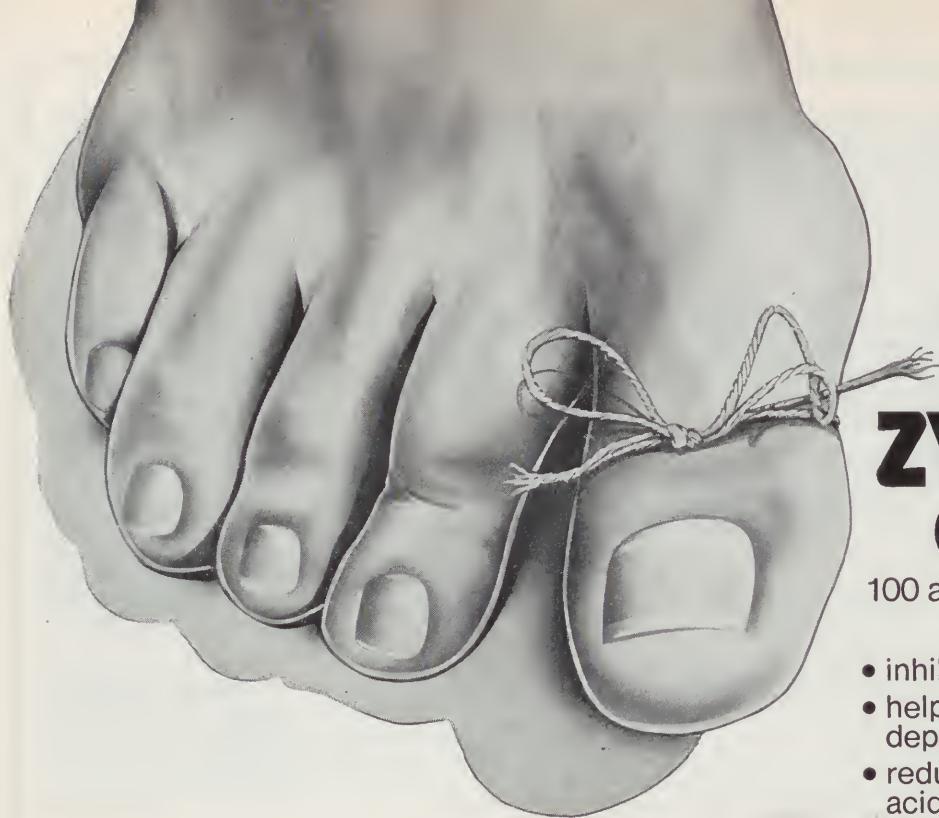
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INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported. In patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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Medical Miscellany

Easier to Find Surgeon to Replace Heart Valve Than Family Doctor to Treat Strep Throat, Sen. Mathias Says

"It is easier to find a heart surgeon to replace your damaged valve than to find a family doctor to treat your strep throat and prevent your valve from being damaged in the first place," according to US Senator Charles McC. Mathias, Jr. (R-MD).

The Maryland senior Senator addressed the Maryland Chapter of the American Academy of Family Physicians in Bethesda recently.

"Until we resolve this paradox, we will never reverse the present trend in health care costs," he warned. "If we could increase the number of family physicians, we would decrease demand for hospital care and subspecialty, high technology care."

Pointing out that "Health care costs have risen two-and-a-half times faster than the cost of living," Sen. Mathias lamented that "People can no longer afford to get sick."

If hospital stays could be foreshortened for each patient by one day, "It would save us \$5 or \$6 billion at the rate costs are going up," he predicted.

"Developments in medical research and technology have brought medical treatment in this country to the point where the United States is the technical envy of the world, but, somehow, despite every new triumph, the system inches closer and closer to bankruptcy," Sen. Mathias continued.

"These technological developments have fostered a decline in general practice. Too many medical students have chosen, and are still choosing, to become subspecialists, rather than to go into primary care," he explained.

In Maryland, he said, only about 10% of the physicians are family physicians. "In fact, there is only one family physician for every 4,876 people in the state, whereas I am told that we need at least one family physician for every 2,500 people."

Discussing possible remedies, Sen. Mathias said that "We do have four excellent civilian Family Medicine residency programs in Maryland and having a Department of Family Medicine in our state Medical School is also an important step, but that still is not enough."

He recommended that third party payors (Federal, State and private) "Begin to reimburse family physicians more equitably and at rates that would bring their incomes more into line with their subspecialty colleagues. Simple justice demands that they be paid the same fee for the same service." □

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Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL as cases become final.

IN THE MATTER OF MOHAMMAD BALOCH, MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Disposition Agreement

The Commission on Medical Discipline of Maryland (the "Commission") and Mohammad Baloch, MD, (the "Respondent") enter into the following Agreement, this 18th day of December 1978, regarding certain charges filed by the Commission on or about Jan. 13, 1978, against the Respondent's license to practice medicine in the State of Maryland:

1. The Respondent shall execute the attached Order simultaneously with his execution of this Agreement.

2. The Commission will defer execution of the attached Order for three years, provided, however, that the Commission shall execute the Order upon the earlier occurrence of any of the following:

(a) The practice of medicine by Respondent other than in the military service of the United States;

(b) The filing of an application by Respondent for a medical license in any state, territory or possession of the US, or the District of Columbia;

(c) The filing of a petition by the Respondent with the Commission requesting a determination that he is competent to practice medicine;

(d) The failure of the Respondent to enter into a residency program acceptable to the Commission within one year of the date of this Agreement;

(e) If admitted to a residency program, the termination of Respondent's participation in said residency program without the Commission's permission.

(f) The failure of Respondent to furnish quarterly reports to the Commission from his supervising medical officer describing his status and his practice of medicine in the military service.

3. Should the Commission have occasion to execute the attached Order prior to the expiration of the aforesaid three year period, it may do so without a hearing, but such action shall occur no sooner than 10 days after notice is sent to Respondent at the following address:

Mohammad Baloch, MD
c/o John R. Francomano, Esq.
501 Keyser Bldg.
Calvert and Redwood Sts.
Baltimore, MD 21202.

WITNESS the hands and seals of the Commission on Medical Discipline by JOHN E. ADAMS, MD, Chairman and MOHAMMAD BALOCH, MD, the day and year first above written.

MOHAMMAD BALOCH, MD
JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline of Maryland

STATE OF MARYLAND, COUNTY/CITY OF BALTIMORE,
to wit:

I HEREBY CERTIFY, that on this 18th day of December, 1978, before me, the subscriber, personally appeared MOHAMMAD BALOCH, MD, who made oath in due form of law that the foregoing Agreement is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

Notary Public

STATE OF MARYLAND, CITY/COUNTY OF BALTIMORE,
to wit:

I HEREBY CERTIFY, that on this 19th day of December, 1978, before me, the subscriber, personally appeared JOHN E.

ADAMS, MD, Chairman, Commission on Medical Discipline of Maryland, who executed the foregoing Agreement on behalf of the Commission on Medical Discipline of Maryland.

AS WITNESS my hand and Notarial Seal.

ARDINE P. JOHANSEN
Notary Public

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention pursuant to the provisions of Art. 43, Sec. 130 of the Annotated Code of Maryland, the Peer Review Committee of the Medical and Chirurgical Faculty of the State of Maryland initiated an investigation into the medical practice of the Respondent, Mohammad Baloch, MD. Thereafter, the Commission on Medical Discipline of Maryland, after considering the report and recommendation submitted by the Peer Review Committee, determined to charge the Respondent with certain violations of the Code. The violations charged involved the following subsection of Article 43, Section 130 (h):

(18) Professional incompetence.

Appropriate notice of the charges and the grounds from which they arose was given to the Respondent and a hearing on said charges was scheduled to be held on Feb. 14, 1978. Prior to the convening of that hearing, the Commission was contacted by John Francomano, Esq., the Respondent's counsel, with regard to the charges. Following discussions between Mr. Francomano and Jack C. Tranter, Assistant Attorney General, counsel for the Commission, the Respondent agreed to enter into a Consent Order as proposed by the Commission.

Findings of Fact

The Commission finds:

1. That Respondent maintained inadequate office equipment for the performance of minor surgery in a rural family practice setting.

2. That the Respondent's medical records are not consistent with the standards required from a competent practitioner of family medicine in Maryland.

3. That the Respondent lacked sufficient medical knowledge to engage in the unsupervised practice of family medicine.

Conclusions of Law

Based upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the charge has been substantiated and that Respondent is GUILTY of that charge.

Order

From the foregoing Findings of Fact and Conclusions of Law it is this 12th day of December, 1978, by the unanimous vote of the entire Commission on Medical Discipline

ORDERED that the license to practice medicine and surgery in the State of Maryland heretofore issued to the Respondent Mohammad Baloch, MD, by the Board of Medical Examiners is hereby REVOKED: and be it further

ORDERED that the Commission shall STAY the revocation of Respondent's license and place Respondent on PROBATION subject to the Conditions the Commission deems appropriate, if Respondent:

1. Successfully completes a residency program acceptable to the Commission and demonstrates to the Commission's satisfaction that he is competent in his chosen field;

2. Becomes Board certified in his chosen field or

3. Otherwise demonstrates to the Commission's satisfaction that he is competent to practice in his chosen field; and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners of Maryland in accordance with Article 43, Section 130 (m) of the Annotated Code of Maryland.

JOHN E. ADAMS, MD
Chairman

Consent

By this Consent, I hereby accept and submit to the foregoing Order. While I make no admissions as to the Findings of Fact and Conclusions of Law, I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights. I further recognize that the Commission's execution of this Order is subject to the terms of a Disposition Agreement dated December 19, 1978.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

MOHAMMAD BALOCH, MD

STATE OF MARYLAND, COUNTY/CITY OF BALTIMORE,
to wit:

I HEREBY CERTIFY, that on this 19th day of December, 1978, before me, the subscriber, personally appeared MOHAMMAD BALOCH, MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.
Notary Public ☐

IN THE MATTER OF LEONARD H. FLAX, MD BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

At its Nov. 21, 1978 meeting, the Commission on Medical Discipline (the "Commission") considered a report and recommendation submitted by letter dated Oct. 25, 1978 by the Baltimore County Medical Association regarding the surgical care rendered by Leonard H. Flax, MD (the "Respondent") for his patient, Mary J. Ramsey. This report and recommendation resulted from a complaint received by the Commission and a referral of that complaint to the Baltimore County Medical Association for investigation.

Based on the report and recommendation received, the Commission on Nov. 27, 1978 issued an Order for Emergency Suspension of License which order summarily suspended the Respondent's medical license insofar as that license permitted him to engage in operative surgery. A hearing to consider the summary suspension was scheduled for Dec. 5, 1978 to consider whether it would be continued during a complete review by the Commission of Respondent's medical practice and prior to a final decision regarding Respondent's medical competence.

On Dec. 5, 1978 the hearing convened before the following members of the Commission: John E. Adams, MD; John Ball, MD; Jerome J. Coller, MD; Vincent Fiocco, MD; Arthur T. Keefe, MD; Eli H. Lippman, MD; Karl F. Mech, MD and Frank Shipley, MD. John E. Adams, MD presided as Chairman of the Commission. Also present were Jack C. Tranter, Assistant Attorney General, to advise the Commission as to rules of evidence and Stephen J. Sfkas, Assistant Attorney General, to present the case on behalf of the Commission. The Respondent appeared represented by Arnold R. Silbiger, Esquire, his counsel. As a result of that hearing the Commission by Order dated Dec. 11, 1978 continued the suspension imposed by the Commission's Nov. 27, 1978 Order. The Commission also ordered that a comprehensive peer review of Respondent's medical practice be immediately begun and scheduled a hearing for Feb. 6, 1979 to consider the charge that Respondent is professionally incompetent and to consider whether permanent sanctions would be imposed on his medical license.

By letter dated Jan. 12, 1979 the Peer Review Committee of the Baltimore County Medical Association (the "Peer Review Committee") filed a report and recommendation with the Commission relating the results of its comprehensive review of Respondent's medical practice. Prior to the hearing scheduled for Feb. 6, 1979, as a result of discussions between Mr. Tranter

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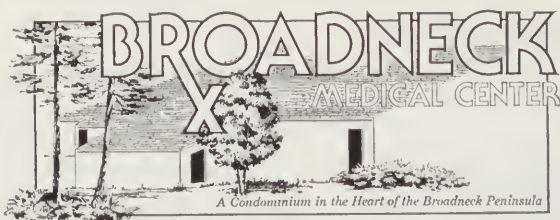
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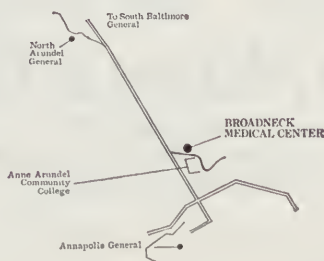
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and Mr. Silbiger, the Commission has determined to enter into the following Consent Order with the Respondent.

Findings of Fact

The Commission finds:

1. That on Apr. 25, 1978, during the performance of a Nissen fundal plication for the repair of an esophageal hiatal hernia for Mary J. Ramsey, the Respondent ligated and divided that hepatic artery and ligated the portal vein.
2. That such actions resulted in massive liver necrosis with death following approximately seventy-two hours after completion of the surgery.
3. That as demonstrated at autopsy, the esophageal hiatus hernia repair was improperly performed.
4. That the care rendered by Respondent for Mary J. Ramsey represents a gross error in surgical treatment and demonstrates a general lack of surgical competence on the part of the Respondent.
5. That the Peer Review Committee in connection with its review of Respondent's practice considered fifteen consecutive cases in which Respondent provided care at Baltimore County General Hospital.
6. That the review of the above fifteen surgical cases revealed no incompetence in the workups or in the surgery performed by Respondent.
7. That the Peer Review Committee's review of Respondent's practice indicates that his office records, though voluminous, often fail to distinguish between significant and insignificant information and also fail to contain a patient's history and physical examination recorded in any one place in a chronological fashion.
8. That the Peer Review Committee's review of Respondent's practice indicates that his hospital records are consistent with the standards expected from a competent surgeon.

Conclusions of Law

Based on the foregoing Findings of Fact, the Commission accordingly adjudicates the Respondent **GUILTY** of the charge of professional incompetence insofar as that charge relates to the care he rendered for Mary J. Ramsey.

Order

Upon the foregoing Findings of Fact and Conclusions of Law it is this 23rd day of February, 1979 by the majority vote of those members of the Commission on Medical Discipline hearing this case

ORDERED that the Suspension of the Respondent's medical license imposed by the Commission's Dec. 11, 1978 Order which prohibited him from performing operative surgery is hereby discontinued; and be it further

ORDERED that Respondent is hereby **REPRIMANDED**; and be it further

ORDERED that Respondent is hereby placed on **PROBATION** subject to the following conditions:

1. That Respondent not perform any major surgery other than in the hospital setting.
2. That Respondent not perform any major surgery in any hospital unless such surgery is performed under the direct observation of the Chief of Surgery or some other physician designated by the Chief of Surgery and acceptable to the Commission.
3. That Respondent shall arrange for the Chief of Surgery or the other physician directly observing his hospital based surgery to submit semi-annual reports to the Commission provided, however, that reports are to be made immediately if a problem is observed.
4. That the Respondent shall submit to a semiannual review of his practice by the Peer Review Committee.
5. That Respondent shall arrange for the Peer Review Committee to submit semiannual reports of the review of his practice to the Commission.
6. That Respondent shall discontinue the performance of vasectomies, circumcisions and lymph node biopsies in his office. He shall confine his office surgery to simple skin lesions which

can be performed under limited local anesthesia, to varicose vein injections, to excision of superficial lipomas, to excision of sebaceous cysts of the skin, to simple excision of ingrown toenails, to incision and drainage of superficial abscesses, to incision and drainage of pilonidal cysts and to incision of thrombosed hemorrhoids. Any other office surgical procedures not included in these categories shall be performed only after written permission from the Commission has been obtained.

7. That Respondent shall obtain at least 100 hours of AMA Category I Continuing Medical Education in each year and be it further

ORDERED that if Respondent violates any of the foregoing Conditions of Probation, if a report submitted by the Peer Review Committee indicates that he is not practicing competently, or if a report submitted by the physician who observes his hospital-based surgery indicates that he is not performing competently, after notification and a hearing, the Commission may revoke the Respondent's license or impose any other disciplinary sanction it deems appropriate and be it further

ORDERED that one year after the date of the Order the Commission will entertain a petition from Respondent to modify Condition #2 so that thereafter it would only be necessary that he be directly observed when he is performing a surgical procedure that had not been previously performed under direct observation; and be it further

ORDERED that three years after the date of this Order, the Commission will entertain a petition to terminate Respondent's probationary status. At such time, if the Commission believes that complete reinstatement would not be appropriate, it may alternatively consider a request to modify one or more of the conditions of Respondent's probation; and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners in accordance with the Maryland Code, Art. 43, Sect. 130 (m).

JOHN E. ADAMS, MD
Chairman
Commission on Medical Discipline

Consent

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. While I do not concur with and make no admissions as to the Findings of Fact and Conclusions of Law made by the Commission, I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, and to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation, I may suffer the revocation of my license to practice medicine in Maryland.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

LEONARD H. FLAX, MD
STATE OF MARYLAND, CITY/COUNTY OF
..... to wit:

I HEREBY CERTIFY, that on this day of 1979 before me the subscriber personally appeared **LEONARD H. FLAX, MD** and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.
Notary Public

IN THE MATTER OF HARVEY BARRY JACOBS, MD BEFORE
THE COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

**Findings of Fact, Conclusions
of Law and Order**

Upon certain information coming to its attention pursuant to the provisions of Art. 43, #130 of the Annotated Code of Maryland, the Physician/Patient Relations Committee of the

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Medical and Chirurgical Faculty, the state medical society, conducted an investigation of Harvey Barry Jacobs, MD (the "Respondent"). Thereafter, the Commission on Medical Discipline of Maryland (the "Commission") after considering the reports and recommendation submitted, determined to charge the Respondent with violation of the following subsection of Art. 43, §130 (h):

(4) The physician has been charged with a crime involving moral turpitude, and has entered a nolo contendere or guilty plea or has been convicted of the crime.

Appropriate notice of the charge and the ground from which it arose was given to the Respondent and a hearing on said charges was held on Apr. 3, 1979. The following members of the Commission were present at the hearing: John E. Adams, MD; John G. Ball, MD; Vincent J. Fiocco, Jr., MD; Arthur T. Keefe, MD; Eli M. Lippman, MD; Francis C. Mayle, Jr., MD and Frank H. Shipley, MD. John E. Adams, MD presided as Chairman of the Commission. Also present were Jack C. Tranter, Assistant Attorney General, to advise the Commission as to rules of evidence, and Constance H. Baker, Assistant Attorney General to present the case on behalf of the Commission. The Respondent appeared without counsel.

Following introduction and opening statements, Mrs. Baker presented the case on behalf of the Commission. Mrs. Baker introduced the following documentary evidence:

1. *State's Exhibit #1*: Certified copies of Judgment and Probation/Commitment Order and Docket Entries in *United States of America v. Harvey Barry Jacobs*, Case No. 76-291-A, US District Court for the Eastern District of Virginia.
2. *State's Exhibit #2*: Certified copy of the Indictment in *USA v. Harvey Barry Jacobs*, Case No. 76-291-A, US District Court for the Eastern District of Virginia. Pursuant to an objection by the Respondent, Paragraphs G, J and K were stricken from the copy of the Indictment accepted into evidence.
3. *State's Exhibit #3(c)*: Certified copy of the transcript of the instructions to the jury in *USA v. Harvey Barry Jacobs*, Case

No. 76-291-A, United States District Court for the Eastern District of Virginia.

4. *State's Exhibit #4*: Copy of an unpublished *per curiam* decision of the US Court of Appeals for the Fourth Circuit in *USA, Appellee v. Harvey Barry Jacobs, Appellant*, Case No. 77-2022.
5. *State's Exhibit #5*: Copy of *Jacobs v. US*, No. 77-1424, 98 S. Ct. 3071 (1978)
6. *State's Exhibit #6*: Copy of 18 USC §1341

After the admission of the above specified documentary evidence, Mrs. Baker argued that the Respondent had been convicted of a crime involving moral turpitude. Copies of the following cases were given to the Commission as support for this claim. *Attorney Grievance Commission v. Klauber*, 283 MD 597 (1978); *Attorney Grievance Commission v. Reamer*, 281 MD 323 (1977); *Attorney Grievance Commission v. Walman*, 374 A.2d 354 (1977); *Maryland State Bar Association Inc. v. Kerr*, 272 MD 687 (1974); *Braverman v. Bar Association of Baltimore City*, 209 MD 329 (1955); *Board of Dental Examiners v. Lazzell*, 172 MD 314 (1937). Mrs. Baker then rested the Commission's case.

The Respondent then proceeded to present his case. He professed that he wanted to demonstrate to the Commission that he had been erroneously convicted of 18 USC §§1341 and 2. Mrs. Baker objected arguing that such an inquiry was nothing more than an attempt to retry the criminal case and was an effort inappropriate to this forum. The Commission ruled that it would not accept any evidence regarding the validity or correctness of Respondent's conviction. The Respondent objected to this ruling. He continued his presentation by offering testimony on his own behalf as well as the following documentary evidence.

Respondent's Exhibit #1: Copy of a certificate indicating that the Respondent was awarded First Prize in the Harry H. Kerr Essay Competition, The Washington Hospital Center.

He also sought to introduce a letter dated July 12, 1976 to Vernon L. Case, Manager, the Travelers Insurance Co., from Robert L. Griffith, Program Officer, Contractors, Bureau of Health

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Insurance, Department of Health, Education and Welfare. This document was marked for identification as *Respondent's Exhibit #2* but was not admitted into evidence. After closing arguments by Mrs. Baker and the Respondent, the hearing was concluded.

During the hearing, two additional pieces of documentary evidence were introduced by the Commission itself.

1. *Commission's Exhibit #1*: Letter dated March 29, 1979, from Stephen J. Crittenden, Supervisor, Richmond Medicare B, the Travelers Insurance Co., to John E. Adams, MD, Chairman, with a Commission-issued subpoena attached.
2. *Commission's Exhibit #2*: Letter dated March 28, 1979, from Robert L. Griffith, Director, Division of Program Operations, Medicare Bureau, Department of Health, Education and Welfare to John E. Adams, MD with two Commission-issued subpoenas attached.

Findings of Fact

The Commission finds:

1. That on May 27, 1977, the Respondent was convicted of a fraudulent scheme to obtain monies from Medicare and Medicaid in violation of USC Title 18, §§ 1341 and 2, Counts 1, 4, 5, 7 and 9 merged into one count in the US District Court for the Eastern District of Virginia, Case No. 76-291-A.
2. That the Respondent was sentenced to two years imprisonment.
3. That the Respondent's conviction was affirmed by the US Court of Appeals for the Fourth Circuit, Case No. 77-2002, in an unpublished *per curiam* opinion dated February 6, 1978.
4. That the Respondent's petition for a writ of certiorari was denied by the US Supreme Court on June 12, 1978, 98 S.Ct. 3071 (1978).
5. That review of *State's Exhibit #3(c)*, the judge's instructions to the jury, *State's Exhibit #2*, the indictment, and *State's Exhibit #1*, which reflects the jury's verdict, indicates that in finding the Respondent guilty of violating 18 USC §§1341 and 2, mail fraud and aiding and abetting mail fraud, the jury determined and found that the Respondent acted with an intent to defraud.

Conclusions of Law

The Commission concludes as a matter of law:

1. That Maryland law provides that a conviction of mail fraud and aiding and abetting mail fraud constitutes a crime involving moral turpitude only if the jury finds that the acts alleged were committed with an intent to defraud, *Attorney Grievance Commission v. Klauber*, 283 MD 598 (1978). *Attorney Grievance Commission v. Reamer*, 281 MD 323 (1977).
2. That the Respondent's conviction of a fraudulent scheme to obtain monies from Medicare and Medicaid in violation of 18 USC §§1341 and 2 constitutes a conviction of a crime involving moral turpitude since consideration of the allegations of the indictment along with the jury charge indicates that in rendering its guilty verdict the jury found that the Respondent acted with an intent to defraud. Accordingly, the Commission adjudicates the Respondent GUILTY of the charge, Article 43, §130 (h) (4) of the Annotated Code of Maryland.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of May, 1979 by the unanimous vote of those members of the Commission hearing the case,

ORDERED that the license to practice medicine and surgery issued to the Respondent, Harvey Barry Jacobs, MD by the Board of Medical Examiners is hereby REVOKED.

JOHN E. ADAMS, MD

Chairman

Commission on Medical Discipline

□

DOCTORS TAKE NOTE:

Oct. 24, Selected Topics for Daily Med. Care, Franklin C. Lane Coll. Ctr., Frostburg (MD) State Coll. For details, call Univ. of MD Prog. of Cont. Educ. at (301) 528-3956.

Dec. 7-8, Symp. on Gynae. Oncology, BWI Airport Internatl. Hotel. For details, call above number or (301) 528-3856.

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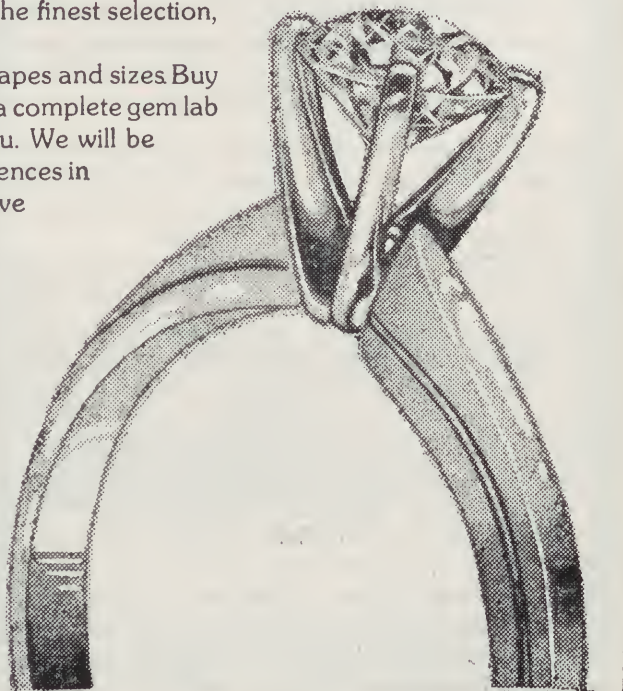
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Baltimore City Medical Society

CONRAD ACTON, MD, Editor

General Meeting

(In Dr. Acton's absence, the highlights of the BCMS General Meeting on June 7, 1979 are reported by John H. Hirschfeld, MD.)

Howard Davidov, MD, Chairman of the Membership Committee, presented the following applicants for Active Membership: Drs. Ron Byrenick, Joseph A. Ciotola, James P.G. Flynn, Calvin F. Fuhrmann, Kenneth C. Gertsen, Meyer R. Hanman, John A. Kisly, Chevrru V. Krishnar, James K. Smolev and Harry S. Steven. They were elected and presented with their Membership Certificates.

Mrs. Anderson Speaks

Mrs. Helen Anderson, President of the Women's Auxiliary to the BCMS, spoke briefly, telling of the need for more members. She urged that our spouses should all join. New Auxiliary members automatically become members of the Maryland and AMA Auxiliaries. She reported a first for the Auxiliary. A male, spouse of a female MD was elected a member of the Auxiliary. She also talked of finances, that the group had this year raised \$1,500 for scholarships, for helping the Primary Alcoholism Treatment Center and for helping the Committee on Physical Fitness. She brought up the importance of cash for AMA-ERF (not a raffle). The \$1. charge for AMA-ERF tickets would be considered a contribution for a Medical Education Project of the Auxiliary: what to do about teenage drinking.

Dr. Whitfield's Talk

Carlton Halle, MD, Chairman of the Professional Education Committee, introduced Charles L. Whitfield, MD, whose topic was *New perspectives and Success in Managing the Alcoholic Patient*.

Dr. Whitfield is Director of Alcohol and Drug Abuse Education at the University of Maryland Medical School. He is an excellent teacher and has published many papers. He spoke about three main areas: 1) How do you help an alcoholic recover? 2) How do you make the diagnosis of alcoholism? and 3) Drinking interference with health, job and social activity.

Treatment success means abstinence, or longer periods thereof, and (successful) coping of the family with the disease. Dr. Whitfield emphasized the *danger periods* for the alcoholic, such as holidays, birthdays, anniversaries and other celebrations. Vacations and stress situations also foster recidivism. On the average, he found alcoholics will go through three-eight serious attempts at abstinence to reach sobriety. Crisis situ-

ations will push the alcoholic to seek treatment. The reported success rate is 50-90%; 10% have no perceived crisis. The failures accept skid row. Their intelligence is not intact! Dr. Whitfield gave illustrations of treatment methods and emphasized the importance of calling alcoholism by its name instead of euphemizing it.

Board of Directors Meet

The BCMS Board of Directors at its June 12, 1979 meeting noted a conflict between its meetings on the second Tuesday with meetings of other groups in which several Directors serve. The Directors will meet on the fourth Tuesday from now on.

Financial Report

Kennard L. Yaffe, MD, our Treasurer, interpreted the monthly balance sheet. As projected for the next six months, there may be a \$12,000 deficit between income and expenditures unless the slowly-accrued reserves are tapped. A dues increase two years in a row is not considered appropriate public relations procedure. President Albert M. Antlitz, MD disclosed a new approach that Med-Chi is considering. Instead of dues fixed by specific Bylaw, a variable rate would be used. A budget for each year would be developed sufficiently in advance to be studied and approved by the members. The total, divided by the number of active members, would be the annual dues assessment. This idea will be studied by our own Finance Committee.

Dr. Bormel Reports

Paul Bormel, MD, President of the BCMS Foundation, reported to the Directors on the assets and grants of the Foundation: 18 applications were received and four grants of \$1,000 each were awarded. These went this year to John E. Gordon, Richard D. Kagen, Cecil L. Parker, Jr. and Marilyn D. Short. All are third or fourth year medical students and attend schools outside of Maryland.

Dr. Atkins' Recommendation

Raymond M. Atkins, MD, Chairman of the Ad Hoc Committee on Third Party Carriers, recommended NON-participation in an insurance company's voluntary second surgical opinion program at this time. The Committee considered that participation might amount to a tacit endorsement or advocacy of such policy and so help forge another chain of restraints on surgery. The meager data available shows no rush by patients to obtain second opinions, or benefits to patients, even when utilized. Safeguards presently observed in Mary-

land hospitals are very adequate. Who knows when clamor for a *third* opinion might develop—or when it ultimately could stop?

Fred Heldrich, MD, Chairman of the Professional Education Committee, seems caught in the ebb and flow of proposed general meetings in 1980. Several months ago a list of about 12 topics was proposed for next year and sent to the Directors for consideration prior to preparation of the final programs.

The new topics submitted reflect the qualities suggested by the Directors when reviewing the first list. Your representative regrets that "Pharmacologic Calvinism," which seems most fascinating to him, was low on the Directors' rating. ☐

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Alcoholism Services at a Community Health Center

By H. OLGA ZABLOTNY

Ms. Zablotny can be contacted for reprint and other data at 307 John Ave., Linthicum, MD 21090.

Is there help for the alcoholic and his family? Fortunately, for residents of Maryland, the answer is YES! There are many agencies and organizations ready with available assistance. One of these is the Carruthers Community Health Center which serves the residents of South Baltimore. It is housed in the old Holy Cross School located at 112 E. West St. Bought for \$1 and renovated at a cost of \$60,000, it is today a busy place. Funds for its operation are received from Federal, State and city governments.

The Carruthers Community Health Center serves an area that is bordered by Pratt St. to the north, Russell St. on the west and the Patapsco River on the south and east. Here can be found many small, low-cost row houses, but also in this section is the exciting Inner Harbor and Federal Hill, an exclusive neighborhood of renovated, historical homes. In this peninsula can also be found a great deal of industry, including such companies as Bethlehem Steel, Am Star, the Chessie System, General Electric and the Baltimore Gas and Electric Co., which has a generating station.

The Carruthers Center is an outpatient health center ministering to the needs of the emotionally-ill clients, drug and alcohol abusers. It also provides counseling services and therapy to adults and children on both an individual and group basis. Approximately 23,000 people reside in this section. There are 400 active clients who are presently benefiting from the services being offered at the Center. About 200 clients are seen weekly. Of this number about 50% of the adults and 50% of the children suffer from alcohol-related problems.

The peninsular region of South Baltimore has its own unique qualities. The population is predominately white and is comprised of many ethnic groups, and the vast majority of the residents are blue collar workers. Many of the homes here have been inhabited by generations of the same family; however, transients, some of whom can be classified as the Appalachian type, also make their homes here. Drinking in this community is an integral part of the life and entertainment. Indeed, drinking is well-established as part of the culture. A bar, which appears on practically every corner, helps reinforce the alcohol habit and compounds the problems associated with this chemical. Drinking and drunkenness are often considered normal behavior and certain attitudes persist. "All my friends do it; Why shouldn't I drink?; What else is

there to do?" Drinking also bolsters the macho image.

Although the Center, other agencies and organizations are ready and eager to give help, getting clients to avail themselves of the services is not easy. Many alcohol abusers and their families feel there's a stigma attached to seeking help. Motivation is lax. Many don't see their drinking as a problem. Appointments set up for children at the Carruthers Community Health Center are often broken due to the lethargy of parents who don't see that the children get to the Center. Sporadic counseling, which isn't nearly as effective, is the result. The family must be involved for best results. Fortunately, the situation seems to be improving. More families have sought therapy this past year than ever before.

Some clients are sent to the Carruthers Center through referral. Probation officers, doctors, hospitals and industries—such as Bethlehem Steel, the Chessie System and General Electric—find counseling and therapy important factors in the rehabilitation of problem drinkers. At the time of admission, many clients are not happy about the referral, although the benefits derived from the treatment offered are tremendously important to those who take their problems seriously.

The Director of Alcoholism Services of the Carruthers Center is a young social worker named Patrick Scally. Years ago, while attending college, Mr. Scally, a native of South Baltimore, returned to his neighborhood several hours a week to carry out his field placement. After graduating in 1972, he came back to this area to work permanently.

Mr. Scally and his staff are meeting the challenges in many ways. In addition to the work done at the Center, the staff is part of COPO (Coalition of Peninsula Organization), a group representing health agencies, the Police Department and churches, which studies the problems and tries to find solutions. COPO also informs and aids the neighborhoods. A task force holds weekly meetings at Southern High School, which is located in this district. The curriculum at the school today includes courses in alcohol and drug abuse. AA meetings are held daily and, on Sundays, there are two AA meetings.

In 1976, Friendship House, a halfway house for alcoholics who have no home to immediately return to, was established. Mr. Scally is very happy about this achievement. Friendship House is funded by a State grant. Here group meetings are held and therapy continued. Many of the members help with neighborhood meetings and projects.

The success rate in the rehabilitation of alcoholics

is believed to be rather consistent. It is estimated that the Carruthers Center is of some help to 50% of those involved in alcohol abuse. Another 25-30% have managed at least three months of sobriety. Occasionally, former clients who have managed to stay sober for longer periods of time visit the Center.

Women alcoholics generally do not go for help until much later in life. Usually, these women have serious physical problems and it is the hospital which sends them to the Center for help. Children who get off dangerous drugs like PCP often replace the drug addiction with alcohol addiction. When senior citizens are in need of help, it is generally senior citizens' organizations which are instrumental in getting the problem drinkers to seek assistance. Antabuse is being used in the treatment of alcoholics and having positive results. □

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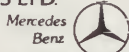


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In Memoriam:

I. Ridgeway Trimble, MD (1900-79)

By ROBERT C. KIMBERLY, MD

For reprint and other data, Dr. Kimberly can be contacted at 1120 Bellemore Rd., Balto., MD 21210.

Maryland lost one of its most eminent physicians on Apr. 17, 1979, when Dr. I. Ridgeway Trimble died of a brain tumor at the age of 78. Born in Baltimore of a distinguished line of physicians and soldiers, Dr. Trimble was educated at Gilman School and Princeton University, graduating from the Johns Hopkins Medical School in 1926. He practiced surgery in Baltimore until 1942, when he was commissioned a Lieutenant Colonel in the United States Army and appointed Chief of the Surgical Service of the 118th General Hospital, one of the Army hospitals affiliated with Hopkins. In 1943, he was appointed to the staff of General Douglas MacArthur as Chief Surgical Consultant for the Southwest Pacific Theater of Operations, being responsible for the surgical care of all Army personnel in the theater.

At the end of the war, Col. Trimble arrived in Japan with the first contingent of American troops to enter that country and was the first American medical officer to visit Hiroshima after the atomic bomb had been dropped on that city in August, 1945. He was awarded the Legion of Merit before being relieved of active duty in 1946, and the same year was one of the founders of the Society of Medical Consultants to the Armed Forces, serving as its President in 1952, when he also organized the Civilian Consultant Program for Maryland, assigning former medical officers to assume responsibility for the medical care of military personnel and their dependents at Fort Meade, the Aberdeen Proving Ground and the Army Chemical Center at Edgewood. He made several trips to Europe and the Far East, visiting all the overseas Army hospitals for

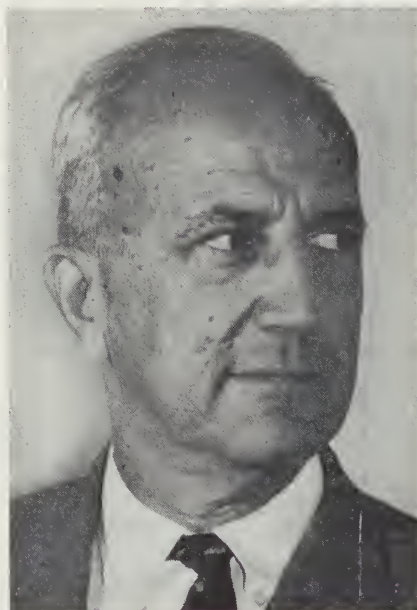
the Surgeon General of the Army, too.

Resuming the practice of surgery in Baltimore, Dr. Trimble found time to write the chapter on surgery of the stomach for Lewis's *System of Surgery*. He organized the vascular clinic at the Johns Hopkins Hospital and taught many younger surgeons the technique of sympathectomy and the correction of aortic aneurysms.

Dr. Trimble developed the first one-stage operation for cancer of the pancreas, and wrote extensively on surgery of the breast, being a firm believer in the value of the Halstead operation for the radical cure of cancer of the breast.

Dr. Trimble was Professor of Surgery at the Johns Hopkins Medical School as well as at the University of Maryland Medical School, and was on the staffs of seven Baltimore Hospitals. He was a Fellow of the American Surgical Association and the Southern Surgical Association and a member of many other surgical societies, as well as being a founder of the Society for Vascular Surgery.

In 1945, the-then Col. Trimble



DR. TRIMBLE

was married to Dr. Frances H. Smith in Sydney, Australia, who was later a coauthor in some of his writings on surgery of the breast. He is also survived by a daughter, Miss Elizabeth Trimble of Baltimore; two sons, Dr. I. Ridgeway Trimble, Jr. of Santa Monica, CA and Edward L. Trimble of Baltimore.

No surgeon in Baltimore was called on for help by his colleagues more frequently than Dr. Trimble. He would literally go anywhere at any time to help another surgeon or to teach a new technique. His consultations were thorough and precise and his judgment always accurate. His mere presence in a hospital room was a great comfort to the patient, the family and to the attending surgeon. He will be sorely-missed by all, not least by surgeons whom he had many times helped out of difficulties. His unfailing good humor and concern for his colleagues will long be remembered. □

DOCTORS TAKE NOTE:

Sept. 27-30, Folk Med.: *Alternative Approaches to Health and Healing* at Smithsonian Natl. Museum of Hist./Tech., Wash., DC. For details, call (202) 381-6532.

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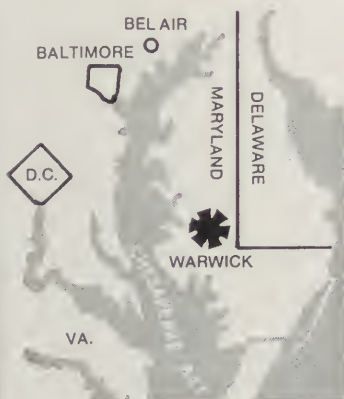


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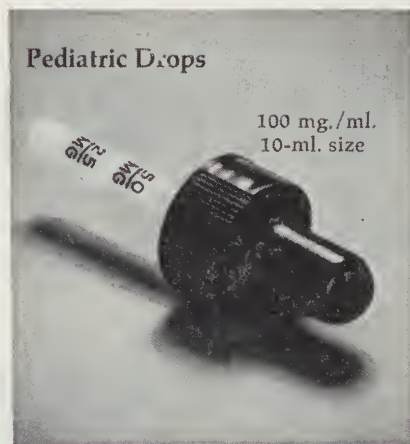
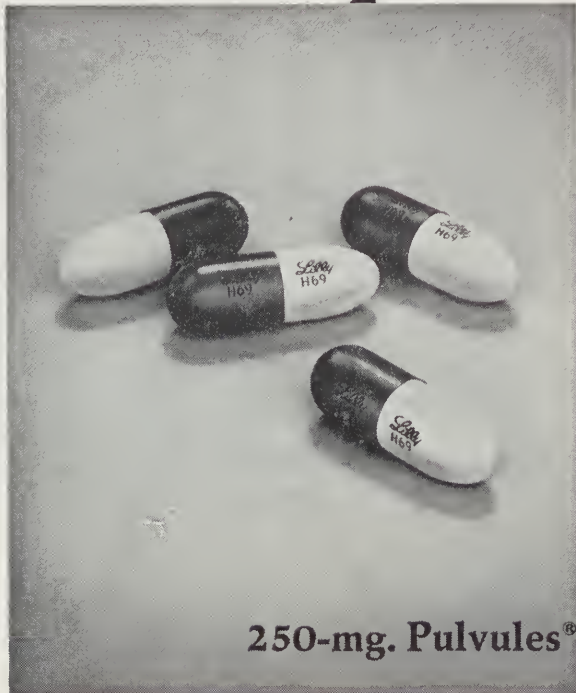


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Medicine in the People's Republic of China

By HUANG CHIA-SSU, BS, MD, MS(Surg.)

Introduction

On May 13, 1979, Huang Chia-ssu, MD, addressed a special meeting of the Baltimore City Medical Society and the Faculty at the Village of Cross Keys' White Oak Ballroom in Baltimore. Dr. Huang is President of the Chinese Academy of Medical Sciences at Peking, Editor-in-Chief of the *Chinese Medical Journal* (English Edition) and Vice President of the Chinese Medical Association. As part of his extended lecture tour of the United States, Dr. Huang participated in the Congress on Medical Education in Washington, DC the week of May 7th.

Arrangements for the visit to Baltimore, cosponsored by BCMS and the Faculty, were made in cooperation with Jackson W. Riddle, MD, PhD, of the AMA Division of Educational Policy and Development.

Dr. Huang was made an honorary citizen of Baltimore by Mayor William Donald Schaefer in a proclamation presented by John B. De Hoff, MD, Baltimore's Commissioner of Health.

ALBERT M. ANTLITZ, MD

President, Baltimore City Medical Society

Dr. Huang's Talk

Shortly after the founding of the People's Republic of China, a health policy consisting of "Being geared to the needs of the workers, peasants and soldiers," "Putting prevention first," "Uniting the doctors of the traditional Chinese and western medicine" and "Integrating the health work with mass movement" (sic) was formulated, and, since then, our health work adhered closely to this policy with enormous progress. Please allow me to present briefly medicine in China under the following headings: health delivery system, medical education the integration of traditional Chinese with modern medicine, the control and extermination of communicable diseases and medical research.

Health Delivery System

When the People's Republic of China was founded in 1949, our health service was extremely inadequate. According to the statistics of the year 1950, there were altogether 2,880 hospitals in the whole country, and they were mostly located in big cities with only a few in the counties. The number of hospital beds were less than 100,000 in the whole country, with 85% in cities and 15% in the counties. As to the vast rural areas, there was practically no health service available.

Under the guidance of the policy "Being geared to the needs of workers, peasants and soldiers," i.e. to serve the vast majority of people, our health delivery system has been very rapidly developed, and attention has been paid to the balanced distribution of health service facilities in urban and rural areas. The number of hospitals in 1965 was 3.7 times that of 1950, and that of hospital beds 7.3 times greater. The increase of hospital beds was much more in the counties, being 11.3 times that of 1950, and the commune hospitals

came into existence with about 95,000 beds. At the end of 1977, there were 64,000 hospitals with 1,776,000 beds. About 40% of the beds were in city hospitals, 20% in county hospitals and 40% in commune hospitals.

At the grass-roots level in the countryside, we adopt a cooperative health system. In our country, the social and administrative organizations for rural areas under the counties are people's communes, under which are production brigades, and under brigades are production teams. The corresponding medical organizations are hospitals, epidemic prevention stations and maternity and child health stations in the counties, the commune hospitals in the people's communes, the cooperative health stations in the production brigades and health workers in production teams, thus forming a health service network. The peasants pay a small sum of money for health care, and an equal or larger amount is paid from a collective accumulation fund of the production teams. In this way, the peasants get free or partially-free medical care in the cooperative health stations. In case of necessity, they are sent to commune or county hospitals, and all or a major part of the charges are paid for by the collective health fund.



THE AUTHOR (left) with **ALBERT M. ANTLITZ, MD** (right), Baltimore City Medical Society President.

(Photograph by Bernadette Lane, BCMS Executive Director.)

All governmental office workers, factory workers and students have free medical care.

Medical Education

In old China, there was no definite system for medical education. Some medical colleges were run by the state, some by private enterprise and still others by foreign missionaries or other foreign organizations, of which the best known was the Peking Union Medical College financed by the Rockefeller Foundation. The colleges run by foreigners followed the educational system of their own countries, while those run by the Chinese gave the type of education which the organizers had themselves received. There was no Chinese system of medical education ever formulated. Medical doctors were classified into the British-American school, the German school, the French school or the Japanese school, and, as a whole, they were called doctors of the western school; there was no Chinese school of modern medicine.

Old China had 32 medical colleges, all located in big cities. For example, in Shanghai, there were seven medical colleges, while in a number of provinces not a single one existed.

Since the liberation, several important measures have been taken in the reform of medical education. The first one was the reallocation of medical schools in 1952 so as to correct their unreasonable geographic distribution. Of the seven medical colleges in Shanghai, the private Tung-te Medical College, the St. Johns University Medical School of an American mission and the Aurora University Medical School of a French mission were combined to form the Shanghai Second Medical College. The private Tung-nan Medical College was moved to Anhui province and became the Anhui Medical College. The Tung-chi University Medical School run by the Germans, was moved to Wuhan city to combine with the Wuhan Medical College. The Shanghai Medical College—later named Shanghai First Medical College—and a military medical college remained in Shanghai. Similar reallocations were done in other parts of our country. Through these measures, medical colleges were more reasonably distributed for the convenience of students, and the teaching staffs were strengthened so that more students could be admitted to these colleges. Later on, as the teaching staffs grew, some medical colleges were assigned the duty of establishing new schools. At present, there are 116 medical colleges in our country, and every province has at least one medical college. The total number of medical graduates since liberation is 350,000. This is 37 times that of graduates for the 19 years (1929-48) before the liberation.

The second measure taken in the reform of medical education was the formulation in 1954 of a unified system for medical education. The applicants for admission to medical colleges should be senior middle school graduates. They should take a national entrance examination and on passing were admitted to the schools according to their choice. The length of schooling was five years in most medical colleges, and six years in a few key colleges. One medical college, de-

voted to the training of scientific researchers, offered an eight-year course. Seven specialties were offered in the medical colleges, namely, general medicine, public health, pediatrics, dentistry, pharmaceuticals, traditional Chinese medicine and traditional Chinese pharmacology. In each specialty, the curriculum and the number of hours for each subject were the same in all the colleges. The senior teaching staffs of different medical colleges were organized to write textbooks for all medical students. In this way, there is unification and elevation of the standard of medical education.

The third measure taken in the reform of medical education was the development of primary and secondary medical educations so as to make up for the deficiency of medical personnel. In secondary medical schools, there are courses for 10 specialties, namely, general medicine, traditional Chinese medicine, public health, maternity and child health, dental technician, nursing, midwifery, pharmacy, Roentgenological technician and laboratory technology. The secondary medical schools take junior middle school graduates and offer a three-year course. In the last few years, as our country is gradually making secondary education universal, some secondary medical schools take senior middle school graduates and offer a two-year course. There are now 435 secondary medical schools with 760,000 graduates in the last 29 years.

Since 1965, we started to give primary medical education, i.e. to train barefoot doctors and health workers. The "barefoot doctors" are young farmers, usually junior middle school graduates. They learn for three-six months the general medical knowledge and technics, and they are taught to diagnose and treat 20-30 kinds of common diseases. Refresher courses for a variable length of time are given to the barefoot doctors in slack seasons in order to gradually improve their knowledge and ability. Now there are about 1,800,000 barefoot doctors with two-three in each production brigade. In production teams, there are health workers who are also young farmers, trained to give primary medical care. There is a total of about 4,000,000 health workers in our country.

The Integration of Traditional Chinese with Modern Medicine

In China, there is a traditional medicine with a history of more than 2,000 years. It has its own medical philosophy and possesses very effective therapeutic measures and medicinal materials, particularly herbs. The traditional medicine and the modern medicine which was later introduced to China from the West did not compliment, but rather were antagonistic, to each other. At the time of the liberation, the traditional doctors far outnumbered the modern ones. According to the statistics of 1950, there were 41,400 doctors graduated from medical colleges, while the number of traditional doctors was 286,000. As the traditional doctors formed a force not to be ignored, to unite the doctors of the two schools became an important task in our country.

Much work has been done in consolidating the doctors of the two schools. First, they are taught to re-

spect and learn from each other, to make up for each other's deficiencies. The traditional doctors sit side by side with the modern doctors to render medical services and discuss medical problems. In our medical colleges, not only the various disciplines of modern medicine, but also the traditional medicine, including its basic theories, pharmaceuticals, acupuncture and moxibustion are taught, and in all the clinical subjects, traditional Chinese methods of treatment are included. In addition, colleges of traditional Chinese medicine were established, the early ones being founded in 1956 in Peking, Shanghai, Canton and Chengtu. At present, there are altogether 24 colleges of traditional Chinese medicine. In these colleges, 70% of the time is spent to teach traditional medicine, and 30% modern medicine, with emphasis on the preclinical subjects. The qualification of students and the length of schooling are the same as colleges of modern medicine.

In 1956, an Academy of Traditional Chinese Medicine was founded under the jurisdiction of the Ministry of Health. In this Academy, well-known traditional doctors are engaged in the study and systematization of traditional medicine, and they pass on their knowledge and experiences to the younger generation. Under the Academy of Traditional Chinese Medicine, there are institutes of the theory of traditional medicine, the traditional Chinese pharmacology, acupuncture, moxibustion and channels, etc., and there are also research hospitals. In these institutes and hospitals, there are laboratory facilities, and the theory and practice of traditional medicine are studied with modern scientific methods. In most of the provinces, there are institutes and special hospitals for traditional medicine.

Since 1958, two-three-year postgraduate courses have been offered by the Academy of Traditional Chinese Medicine and some traditional medical colleges. The participants in these studies are mostly experienced doctors of modern medicine, some being medical professors. When they possess the knowledge of medicine of the two schools, they are in a position to do research work with the combined traditional and modern methods.

Fruitful results have been obtained when the combined methods are used. Take acupuncture analgesia as an example. When the doctors of the modern school learn and gain the experience of treating pain with acupuncture, they utilize pain-alleviating effect for operations to replace anesthetics. Since 1958, acupuncture has been used for more than two million operations, including those of great magnitude, such as intracranial procedures, pulmonary resections and open-heart surgery with the help of extracorporeal circulation. Admittedly acupuncture analgesia has its drawbacks, as there are cases with incomplete alleviation of pain, muscular spasm and reactions to visceral tractions; however, it is advantageous to patients in shock, allergic to anesthetics or too weak to stand general anesthesia.

The treatment of acute abdomen with the combined methods of traditional Chinese and modern medicine has significantly reduced the percentage of patients re-

quiring surgical interventions. For cases of gastric perforations, acupuncture may have the effect of reducing pain and facilitating spontaneous closure of perforation, and medicinal herbs counteract on infections and enhance peristalsis of the gastrointestinal tract. In some cases, cure may be obtained by these measures, while in others, gastrointestinal decompression and antibiotics may have to be added. In about 30% of gastric perforations, operations are required. In cases of choledocholithiasis, stones may be purged out by traditional drugs in about 60% of cases, and this figure is raised to 90% if the treatment is given at the acute onset. For renal stones, there is a success in about 70% of cases by oral medication, and it is still effective in about half of the cases with stones bigger than nine mm. in diameter.

The application of the combined method in the treatment of fractures of bones has broken free from the conventional policy of complete immobilization of fractured ends of bones. By the use of the short splint, not including the joints above and below the fracture, it allows a certain degree of movement of joints, and functional exercises can be started soon after operative reduction of fractures. Compared with the long immobilization with plaster-of-Paris cast, the time for bony union and functional recovery can be considerably shortened.

The Control and Extermination of Communicable Diseases

Guided by the principles of "putting prevention first" and "integrating the health work with mass movement," and particularly after the patriotic health movement in 1952, we have periodically mobilized the mass to eliminate the four pests, i.e. flies, mosquitoes, bedbugs and rats, and educate people to cultivate hygienic habits. Particular attention has been paid to manure disposal and avoidance of water pollution in rural areas. Preventive inoculations have been enforced against some infectious diseases. With these measures, many infectious diseases and some parasitic diseases have been under control. Cholera, smallpox, plague and Leishmaniasis are practically wiped out. The incidences of epidemic encephalitis B, measles and poliomyelitis have been greatly reduced. Diphtheria occurs only sporadically. The campaign against schistosomiasis japonicum has been successful, with 7,500,000 patients cured after treatment, and 9,900,000 square kilometers of land originally infested with snails which are the intermediate hosts of schistosome japonicum cleared. At present, there remain 2,500,000 patients and 3,000,000 square kilometers of infested land. It is still a difficult task to completely eliminate this parasitic disease.

We haven't seen any case of venereal diseases in clinics for many years. As ECG vaccine is given as a routine to newborn babies in cities, and as most of our people enjoy free or cooperative medical care, the incidence of tuberculosis has dropped remarkably.

When infectious and parasitic diseases are on the decline, cardiovascular diseases and cancers head the list of our annual mortality rate. The infant mortality

in Peking before the liberation was about 20%, and now it has dropped to 12%, of which 0.6% died of infectious diseases.

Medical Research

In 1956, our government issued a call to march towards the development of science and technology and formulated a long-term plan for scientific research. In the medical field, the Academy of Medical Sciences was organized in 1957 as an important institution for medical research directly under the jurisdiction of the Ministry of Health. Now, under the academy, there are 19 research institutes which include basic medicine, preventive medicine, clinical medicine and materia medica. The duty of the Academy of Medical Sciences is not only to run its own institutes, but also to help the Ministry of Health to organize and coordinate the medical research work of our whole country. In many provinces, there are medical research institutes under the administration of the local government. All medical colleges also undertake research work, particularly the key colleges, which have the dual responsibility of teaching and research.

In the field of preventive medicine, extensive epidemiological surveys have been done on infectious, parasitic and some endemic diseases, such as goiter. In the last 10 years or so, the epidemiological studies have included noncommunicable diseases, such as cardiovascular diseases and cancers.

Carcinomas of esophagus, liver and nasopharynx are common in our country, and they have their patterns of geographic distributions. Specialists of multiple disciplines have been organized to have cooperative pilot studies in regions with high incidence of cancers. Epidemiology and possible carcinogenic factors are investigated, and early discovery, diagnosis and treatment of cancers are emphasized. Such studies have been carried out in Linhsien, Honan where the incidence of esophageal carcinoma is particularly high. As a result of the survey, many early symptomless cases were discovered, and operations on these cases yielded a five-year survival rate of over 90%. The five-year survival rates for stage I cancer of uterine cervix and stage I cancer of breast are 95-100% and 95% respectively. Besides doing pilot studies, we have made a nationwide cancer survey since 1975, and in three years' time, we have completed this survey and charted a map of geographic distributions of cancers commonly seen in China.

Similar work has been done on cardiovascular diseases. Pilot studies have been made in factories, countryside, plateaus and pastoral areas. Epidemiological surveys are made on hypertension, coronary diseases and stroke, and preventive measures are given to these diseases. In many of these investigated areas, there has been a decrease in the morbidity of hypertension and stroke. According to incomplete statistics covering 11 provinces, the incidence of hypertension and coronary diseases are 5.7% and 4.1% respectively.

In labor hygiene, following the improvement of labor conditions and environment, there has been a marked drop in the incidences of silicosis and indus-

trial poisonings such as that of lead, benzene, mercury and organic phosphorus. In environmental hygiene, we have established a preliminary monitoring system, and have made surveys on our main river systems such as the Yellow, Yangtze and Songhua Rivers, and the atmospheric air in some of our cities. Studies have also been made on the concentrations of cadmium, mercury, arsenic, chromium and fluorine in the environment. These studies give valuable data for formulating our policy on city planning and environmental control. In nutrition and food hygiene, we have made extensive analyses of our principal foodstuffs and a nationwide survey on the nutritional status of our people. Methods for detecting common food poisonings, chemical or biological, have been established and preventive measures taken. Now the incidence of food poisoning in our country has been lowered.

In the field of clinical medicine, besides the improvement in treating diseases by the combined traditional Chinese and modern medicine as mentioned previously, some achievements have been made in other fields as the treatment of extensive burns and reimplantation of completely-severed limbs.

The degree of success in rescuing patients with extensive third-degree burns is the earmark of one's ability in the management of such an injury. In 1966, in the Shanghai Ruijin Hospital, a patient with a third-degree burn covering 90% of his body surface was successfully treated. The eschars were excised in stages, the skin grafts were taken repeatedly from the scalp and the burned areas were temporarily covered with large pieces of homografts with multiple perforations into which seeds of autografts were inserted. Since then, more cases of a similar nature have been treated with success. In the period 1966-75, 29 of 64 cases of extensive third-degree burns covering more than 50% of their body surfaces were cured, the survival rate being 45.3%. We have now on record of successful treatment of seven cases with third-degree burns involving more than 90% of body surfaces, and in one it was 94%. Intensive studies have been made in our country in combating shock, preventing infection, skin-grafting and maintaining the nutritional status and balancing the metabolism of the burned patients.

Since the first successful reimplantation of a completely-severed forearm in 1963, an experience of more than 1,000 successful reimplantations of various parts of extremities have been reported. In 1971, we reported the first case of grafting a severed left foot to the proximal end of a severed right leg in a patient with severe injury of both extremities. When a segment of extremity is diseased or injured, such as a tumor of low malignancy, electric burn or severe segmental injury, we have resected the pathological or damaged segment and reunited the extremity. The first successful operation of this type was done in 1966. In the same year, we started to use the second toe of the patient as a free graft to reconstruct his lost thumb with success. In 1973, successes were scored in free muscle and free skin graftings, and, in 1977, free graftings of the fibula with its accompanying blood vessels. After the microsurgery technique was used in 1973 for reimplantation

surgery, the rate of success for reunion of completely divided fingers reached a new height, being over 90%.

In the field of pharmaceuticals, we have known the natural resources of more than 5,000 kinds of medicinal plants, and have cultivated more than 100 kinds in large areas. Over 30 kinds of tropical medicinal plants, which had to be imported formerly from other countries, are now grown on our own land. In recent years, medicinal fungi such as ergota, ganoderma, gastrodia, poria and grifola have been cultivated not only in farms, but also in factories through fermentation. Chemical analyses and systematic pharmacological studies have been made in more than 200 kinds of medicinal herbs, some constituents of which being found highly valuable. The extraction of gossypol from cotton seed oil is found to have contraceptive effect for males, and this has been on clinical trials in several thousand cases.

In regard to synthetic drugs, we are able to manufacture about 700 kinds of them. This has entirely changed the backward situation of relying almost entirely on the importation of drugs in old China. More than 50 kinds of antibiotics are manufactured in our country by biological or semi-chemical syntheses. In 20 of the 30 kinds of antibiotics synthesized biologically, the producing organisms are isolated from our soil. Creatmycin for B. Coli infection is a new antibiotic made in China.

The Future

Great advances have been made in our health work with respect to the health delivery system, medical edu-

cation, the integration of traditional Chinese with modern medicine, the control and extermination of communicable diseases and medical research, but compared with what has been achieved in advanced countries, we lag far behind. For every thousand people, we have only 1.88 hospital beds and 1.03 doctors. Many infectious and parasitic diseases still exist in China. We are still faced with many medical problems, the solution of which naturally depends on our own effort, but we must learn the good experiences of other countries; 38 years ago, I came to this great country for postgraduate study. I could never forget the happy days I had in the University of Michigan Hospital, where I was trained as a thoracic surgeon by Professor John Alexander, Professor Cameron Haight and many others. I could neither forget this beautiful city—Baltimore—where I had the chance to observe the Blalock operation for blue babies performed by Professor Alfred Blalock himself. I have learned so much from my American professors and colleagues in the past, and now I come to learn again.

I wish to take this opportunity to bring you, medical colleagues and friends of the US, greetings and friendship from Chinese medical circles and the Chinese people. I wish to express my hearty thanks to members of the Maryland medical society for giving me this platform and I want to thank you all for your patience. □

DOCTORS IN THE NEWS:

E. Paul Coffay, MD has been named Vice President for Medical Affairs at St. Joseph Hospital in Towson, MD.

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Medicine Needs Another Mencken

By JEAN-MAURICE POITRAS, MD, FAAP

Dr. Poitras can be contacted for reprint and other data at 107 Edgerton Rd., Towson, MD 21204. He is also in the Department of Emergency Medicine at the North Arundel Hospital at Glen Burnie, MD.

Introduction

Henry Louis Mencken (1880-1956), called the Sage of Baltimore among many other names not always so complimentary, was one of the most renowned and prolific writers of the first half of this Century. He had an overwhelming love and respect for medicine and the medical profession. He could see their faults, but forgave them with the fervor of a doting father.

As well as being one of the truly great writers of the first half of this Century, he was probably also one of its greatest practicing hypochondriacs. As a result, he knew professionally and as a friend nearly every renowned doctor of the Johns Hopkins and University of Maryland Medical Schools and Hospitals.

The medical profession needed his fighting spirit and loving reverence, and he was ever-ready to join the fray. He aided and abetted them whenever he could. He fought their battles with the vigor of knights of old. He attacked and assailed their enemies and was forever in the forefront in the battle against all quackery. He constantly protected and fought for them against bureaucratic misadventures, bungling and incompetency. His pen was a constantly-moving rapier ever jabbing and thrusting.

The following is a short article, labeled as never having been published, from one of the file boxes in the Mencken Room of the Enoch Pratt Free Library in Baltimore clearly demonstrating how much the medical profession today could use another man of

Mencken's caliber and proficiency. The article is undated, but was probably written in the 1930s and is as appropriate today as it was then. Mencken wrote hundreds of published articles which were pro-medicine, anti-quackery and anti-meddling bureaucracy.

Read the article and lament that today we have no knight-errant with upraised banner, no famous scribe to write and publish articles such as the following as did Mencken in his heyday.

Mencken's Prophetic Words of Wisdom

"Belief in quacks is always accompanied by hostility to honest men. It is not by accident that the American Medical Association is one of the principal butts of the whole rabble of Communists, New Dealers, social workers and so on. The medical brethren, during the past two generations, have justified their existence more than any other group of men. They have not only taken an active and effective hand in the progress of medicine as a science; they have also greatly improved it as a profession. The old days of Class C medical schools are gone, and there has been an immense improvement in the operation and usefulness of hospitals. All this the medical men have achieved on their own motion, and to a large extent at their own cost. No other profession has gone so far, or even half so far, in improving its professional competence and social utility, yet, its sole reward is an organized campaign to make it suspect and even infamous, and to turn its members into slaves of the state. In this campaign, all branches of the government have taken a hand—the executive, the legislative and the judicial—and all varieties of uplifters. The same movement, though in less dramatic form, is visible in other fields. The newspapers are denounced, not for their defects, which are plentiful, but for their increasing merits—for example, their effort to report realistically the operations of the governmental bureaucracy and of such groups as that of the labor leaders. When they go along docilely in foreign relations, they are praised, but when they try to tell the truth, they are defamed."

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H.L. MENCKEN

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Our Emerging Technology—How Much is Enough?

By GEORGE R. DUNLOP, MD

For reprint and other data, contact Dr. Dunlop at 65 Elm St., Worcester, MA 01609. Dr. Dunlop is a Past President of the American College of Surgeons.

One of the most difficult and disturbing decisions that faces our society today is the determination of what portion of our resources should be spent on medical care.

England has never faced up to this decision. Instead, she has simply cut back on medical services by increasing the waiting lists until now over one-half million persons are waiting up to four years for elective surgery.

As Elliott Wickes of Michigan State University has pointed out, "People will always want to consume health care that holds out the promise of longer, healthier lives and relief from pain, and since technological progress seems constantly to expand the capacity of medicine to fulfill that promise, the demand is virtually insatiable." Not only is the demand for medical services a bottomless pit, but as Rene Dubois has aptly put it, "To ward off disease or recover health, man as a rule finds it easier to depend on healers than to attempt the more difficult task of living wisely."

To compound the problem, there has been an explosion of emerging technology which gives a physician the capacity to explore, test and monitor most of our bodily functions. This technology is cost-raising rather than cost-saving and has captured the eye and the imagination of most of our younger colleagues. In their enthusiasm it is not unusual for them to confirm a diagnosis by four or five separate modalities, each at a considerable cost to the system.

Not only do we order these support services in a lavish manner, but we are usually unaware of their costs. We are too willing to embrace a new technology before it has been carefully tested and evaluated. Our engineering and scientific community can actually produce new technology faster than the profession can evaluate it.

It took 112 years to implement the principles of photography. Transistors were in production three years after their first experimental demonstration. Hospitals purchased 2,500 machines for freezing the stomach before this treatment was discredited by a careful study of the American Society for Gastroenterology.

You are all aware of how costs have escalated, yet life-expectancy has increased only three years since 1950. Will pouring more money into the system increase the health outcome of the American people? Are we reaching an endpoint and will society have to accept more responsibility for their health by changing their lifestyle?

The increased costs of medical care has become the concern of industry and the taxpayer. Medical costs are production costs. Medical costs raise State and Federal income taxes. Our practice methods and priorities will come under increasing public scrutiny.

If the current trend continues, the cost of health care for the elderly will exceed \$2 trillion by the year 2000.

In their concern, business and government are willing to try any experiment that promises to reduce health care costs. Peer and Utilization review, HMOs, PSROs and second opinion programs are but a few examples.

Dr. Sydney Wolfe's Health Research Group, a subsidiary of Ralph Nader's Public Citizens Organization, is urging HEW Secretary Joseph Califano to ask Congress to add to pending hospital containment legislation a requirement that hospitals participating in Medicare and Medicaid put all hospital-based physicians on salary, including physicians now billing patients directly.

Fired by our emerging technology, the increasing demand for our services with the attendant costs makes it imperative that we know more about the costs and results of these services. The dearth of data for assessing these problems has been called by Elliott Richardson "A nearly fatal deficiency."

We are fast-approaching a situation where a variety of health programs and operative procedures are bitterly competing for the diminishing health care dollar.

Can a profession linked only by its concern for the sick and injured which has traditionally involved itself with the quality—and not the cost—of medical care be expected to provide the necessary answers to a concerned public?

Let us take a closer look at the problem.

The detection of a case of pulmonary embolism in young people is about \$1,000 if a lung scan is used on all patients. If only a subgroup is scanned, the cost drops 40% to \$600, but 5% of the cases are missed. Under these circumstances, the cost of finding the last patient with pulmonary embolism is \$8,500. With an older and more mixed population with pulmonary embolism, the cost is \$2,000 per patient. The cost of identifying and treating, and thereby saving, a life is \$11,300.

The best available data on elective herniorrhaphy indicates that this operation does not prolong life in the elderly (it may or may not improve the quality of life). What has changed the picture over the past 30 years is the surgeon's ability to reduce the mortality of the emergency operation. The skill of surgeons has eliminated the need for the elective operation to save lives in the elderly.

The American hypertensive population numbers 23 million, 90% of whom have an unidentifiable cause of their hypertension and 10% have an identifiable cause. The average cost of detecting a patient with renal vascular disease is approximately \$2,000 and the average cost of curing one is seven-eight times higher. The total cost of discovering patients with renal vascular disease in the American hypertensive population is in the order of billions of dollars and the cost of the surgical cure is \$15,000. These costs result in changes of less than 1% in mortality and morbidity of our hypertensive population.

Elective hysterectomy and oophorectomy in patients in good health will usually result in the increase in life-expectancy of approximately two weeks, primarily by precluding future cancer of the uterus and ovaries. For the patient who is less healthy or older, for example a 50-year-old woman with moderate hypertension, life-expectancy is shortened by elective hysterectomy as a result of the increased risk of surgery. The principle benefits of elective hysterectomy it is assumed are improvements in the quality of life. (Bunker, Barnes and Mosteller.)

Available data on the results of hemodialysis and renal transplantation indicate that 52-60,000 patients will be in treatment at the end of the 10th year at an annual cost of \$700-800 million.

Coronary bypass surgery poses another dilemma to society. What is the optimal medical care for the individual patient may not be optimal when society collectively considers what it is costing. The cost of a coronary bypass operation is between \$10-15,000 per procedure. If the operation were to be performed on only half the potential candidates for surgery, the cost would be \$20 billion, nearly 17% of all current health expenditures and that is only a single procedure employing existing technology.

The Commission on Professional and Hospital Activities compared the effectiveness of sample hospitals with and without coronary care units. The survival rate was 7% better in those hospitals with such units; but if each of the 7,000 hospitals in the United States had 10 such beds, it would cost \$2.5 billion or about \$70,000 per patient.

Of the various modalities that we use, intermittent positive pressure breathing stands on the most shaky scientific ground. Morton Gold of the Department of Anesthesiology of the University of Miami School of Medicine states that the "Overwhelming evidence against IPPB therapy in the surgical patient calls for its abandonment and the substitution of other approaches. The head of respiratory diseases at the Medical School of the University of Massachusetts believes that IPPB has "Never done anything for anyone."

Another issue that needs our attention is the routine annual physical examination. Industry spends millions of dollars on the annual checkup. Could these dollars be better spent on other health programs? Dr. Richard Spark of Harvard is quoted in the *New York Times* as asking this question after reviewing the data of the Kaiser Permanente program: "Why do people who submit to these periodic examinations have the same disease disability and mortality rates as those who seek advice only when they feel sick?"

Dr. Catherine Boucot and her group at the Medical College of Pennsylvania screened 6,136 males over 45 with chest X-rays every six months for 10 years. Initially, none of the men had symptoms of lung cancer. Over the course of the program, however, lung cancer was discovered in 112 of them. These men were given immediate and sustained treatment, but only 8% survived over five years. In the meantime, we have hospital staffs who require routine chest plates on all children prior to tonsillectomy.

Last year in Massachusetts, the cost of support services went up 27% and Blue Shield reserves dropped from \$27 million to \$500,000, whereas physicians' fees and hospital costs went up only 12 and 14% respectively. At the Massachusetts General Hospital X-ray, laboratory and drugs cost the patient on the average of \$127 a day.

Grener and Liptzen reported on a study published in the *Annals of Internal Medicine* analyzing the data of laboratory studies at the University of Rochester Medical Center. The data indicated that laboratory costs were rising faster than the cost of other patient care functions. The average number of tests per patient were 38 for chemistry and 18 for hematology. Tests for blood urea nitrogen, serum electrolytes and a complete blood cell count were repeated every two or three days. The complete blood count was ordered as a package 85% of the time. Urine cultures were ordered more frequently than a urinalysis. Patients in a 15-bed intensive care unit underwent more than twice as many laboratory studies as patients not in the unit. One patient with pulmonary disease in 17 days had 510 tests or an average of 30 a day at a cost of \$3,557. Serum electrolyte examinations were obtained 60 times for \$530, and an X-ray film of the chest was ordered 20 times for \$696. Blood gases were essayed 38 times always with the same outcome, severe hypoxemia. The authors demonstrated that at times the results of ordering tests made little difference to those who did the ordering. Thus, when reports of differential white cell counts for 37 patients were purposely withheld, there was no occasion when the laboratory staff was asked for the report. From an economic viewpoint, all the testing had a strong impact. During the study, the average hospital bill was \$1,818, of which one-fourth was for laboratory tests. These findings led the authors to initiate an educational program about excessive testing and its cost by the development of rational guidelines for optimal use of laboratory procedures, gratifying improvements were obtained.

Another appalling situation in the United States is the fact that we surgeons have so little knowledge of the cost of the support services we order for our patients. An experiment was conducted at the Southern Illinois University School of Medicine involving the effect of price knowledge on the ordering of laboratory tests. A group of medical students with price knowledge ordered an average of \$60 worth of laboratory tests, while those without price knowledge ordered an average of \$111.40 worth of laboratory tests. As responsible physicians we should urge our hospitals to make this information readily-available and, more importantly, we must address the question as to what constitutes an acceptable amount of laboratory testing.

Recently, the President of the Massachusetts Medical Society, Dr. John J. Byrne, wrote to all the hospital administrators in Massachusetts asking them to distribute copies of the charges for laboratory, radiology and other services to all physicians and to send physicians copies of the itemized bills including a breakdown of laboratory and X-ray services. He also urged that these bills be used as source material for education seminars of staff and administration and suggested that this activity might be structured as an ongoing staff responsibility.

Dr. Henry L. Paige, Professor of Medicine at Vanderbilt Medical School, reported an increase in laboratory tests in three years from 2,700,000 to 3,800,000 due, he reports, to the fact that

more physicians, particularly interns and residents, are ordering more and more tests.

I hope that I have convinced this audience that the evidence suggests that we as a profession are showing an increased tendency to rely heavily on an increasing number of support services of whose cost we are unaware and that this trend is threatening the stability of the health financing system. Furthermore, I hope I have raised the question in your minds as to the wisdom of unlimited financing of categorical diseases without national priorities.

As the SMAs move to a new generation and the number of candidates for cardiac pacemakers and coronary bypass grafts increase with the expansion of our geriatric population, the need for priorities become increasingly evident.

The average monthly cost of a pacemaker is \$102. The current cost per unit is about \$900, but the new, improved model with an extended life will cost nearer \$2,000. It is estimated that the cost of pacing the heart is 0.003¢ per heartbeat.

One of the more recent examples of the threat of new technology to the health financing system is the technique of computed tomography. In the past three years, over 300 CT scanners have been installed in the US at a cost of some \$200 million with several hundred orders waiting to be filled. It is estimated that by 1980 there will be approximately 2,500 CT scanning units in the US. As a result of personal inquiry, I find that Canada has about 10.

Currently a CT scanner costs between \$310,000 and \$625,000. These are being purchased or leased and installed in hospitals, doctor's office and even shopping centers. By August, 1976, 15 such scanners of the slightly more than 300 in the US were in physician's offices, and as can be seen, our country is threatened with an over supply which stimulates inappropriate and inefficient use.

The operational cost of a CT scanner is approximately \$400,000 per year. Government—through our planning councils and many of our national professional colleges—have concerned themselves with criteria, not only for the purchase of CT scanners, but for their utilization as well; however, there is little uniformity in these standards. At present, five states have no CT scanners. California has 57, Florida 27, Texas 19 and Ohio 15.

The total body scanner, after emerging through a series of new generations, may be even more effective as a diagnostic tool. We are fast approaching a point where we must recognize that the use of new technology is not necessarily justified simply because it will work. Technology's geometric growth can threaten to generate services and costs rather than to reduce need through controlling illness.

We are now capable of developing lifesaving methods well beyond our capacity to pay for them. Thus, new medical triumphs create new moral and economic issues.

Eli Ginzberg, Professor of Economics at Columbia University, stated: "Let us face up to the fact that we have never had, we do not have now and we will never have enough money to practice the best type of medicine that we are capable of practicing for all the people of the country. We live in a world of limited resources and the public in the last analysis must decide through legislature, through insurance and through direct payments how much of its total budget it is willing to allocate to health."

Dr. David Owen, the Labor Party Minister in charge of the National Health Service in England, said in a recent interview, "The Health Service was launched on a fallacy. First, we were going to finance everything, cure the nation and then spending would drop. That fallacy has been exposed. Now, we must recognize that no country, even if they are prepared to pay the taxes, can supply everything."

We must begin the long and painful reassessment of so many of the services that have become routine in our professional lives and we must assure ourselves that they will stand up under the scrutiny demanded by these modern times.

Such problems as the cost-effectiveness of our medical screens the order of our national medical priorities cannot be made by the professional unilaterally. We have a tremendous research capacity and tradition of problem-solving supported by clinical trials, pilot studies and data-gathering. We have a communication system strengthened by our journals and our meetings, but this is not enough. We can determine the medical effectiveness

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of a procedure and pass judgment on the medical necessity of its use. The allocation of our medical resources is another matter. Here we are dealing with serious social problems and we must inform ourselves and be willing to join with representatives of business, labor and government and the consumer in answering these difficult questions.

My objective is not to discredit medicine's effectiveness in restoring health to the critically-ill and injured, but to point out that if society, including the medical profession, established reasonable health priorities and if we are wise in the allocation of our medical resources, the system may not need to default to the stringent and often unrealistic controls of a Federal bureaucracy.

The individual physician, in his efforts to save the individual patient, cannot be expected to consider the allocation of resources. It is a human impossibility to reckon costs in the care of the sick at the bedside. It should be abundantly-clear that, in this situation, only the reckoning of the medical benefit is permissible. No logic, no economic considerations must allow us to imagine that a case can be made for the medical profession rationing human lives.

The only way out of this dilemma is to make the decision about what services to provide *prior* to the point at which they are needed and prior to the purchase of the expensive technology. *Only then* is it possible to do an objective analysis of the relative benefits of alternate uses of our resources.

Finally, it is important that the profession direct some of its impressive research and investigative capacity to the field of medical economics, thereby placing us in a better position to advise the public as this nation searches for answers to our health care problems.

In addition to monitoring the extreme ends of the practice spectrum, we should concern ourselves more with its center, where most of us practice, recognizing that in this area single daily extravagances can be more costly than those occurring at either end.

The challenge is before us and I hope that you will take a new look at the surgical environment in which you work. Select your support services prudently, direct your investigative capacity toward finding the answers to some of these questions I have raised. Become informed and let your voices be heard in advocating the prudent use of our health services. Convince your students and residents that clinical judgment can in many instances be more important than laboratory reports. Convince them that if they squander our resources on support services, they threaten the very foundation of the fee-for-service system and build the pressures for a Federal takeover of their professional lives; recapture some of the community leadership in these matters that is a part of our heritage and, finally, we must be prepared to join forces with all segments of society in solving these problems of ours within the private sector. □

DOCTORS TAKE NOTE:

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A Model for the Use of Predigested Collagen Amino Acid Liquid Formula Feeding as an Adjunct to a Comprehensive, Medically-Supervised Weight-Reduction Program

By PAUL A. DEVORE, MD and ALAN B. BERGER, RPh

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Introduction

This paper reviews the scientific basis for so-called protein-sparing therapy as an adjunct to a hypocaloric weight-reduction diet, as well as discussing the hazards associated with this sort of dieting regimen. A Model Program designed to be implemented at the level of the primary care physician is presented, along with comparative short-term weight-loss results among similarly-matched groups of patients who followed essentially the same regimen except for the closer monitoring afforded by the Model Program. One of the unique features of this Model Program is that it utilizes the special talents of a pharmacist in a "team approach" to the medical management of a weight-reduction program.

Reports in the lay press have emphasized the hazards of unsupervised use of commercially-available, predigested collagen amino acid liquid formula preparations. Among the hazards reported are hypokalemia with associated cardiac arrhythmias and postural hypotension due to change in body composition while attempting to follow this type of weight-reduction diet.

Protein-Sparing Outpatient Fasting

The theoretical basis for this new form of diet therapy is the "Metabolic Fuel Regulatory System" described by Flatt and Blackburn in 1974.¹ This theory places insulin at the center of an interrelated metabolic system of supply-and-demand that explains many of the problems associated with the fasting state and weight-reduction in general. All ingested foodstuffs induce an increase in circulating insulin; however, dietary carbohydrate induces a greater degree of insulin response than does dietary protein, with dietary fat exerting an intermediate influence on this stimulation of insulin secretion. Furthermore, insulin has a "fat-storing" effect on adipose cells that is counterproductive to the dieter's goal of "fat mobilization." This latter term refers to the mobilizing of triglyceride (the storage form of excessively-eaten carbohydrate) from the fat cell, with its breakdown into free fatty acid and glycerol. Not only does insulin promote the storage of excess caloric food intake within adipose cells, it also actively blocks this breakdown of triglyceride at the level of the adipose cell. Therefore, the ideal weight-

reduction diet should minimize insulin secretion so that the mobilization of free fatty acid from fat depots can be maximized during a hypocaloric dietary regimen. Flatt, Blackburn and Bistrian¹⁻² with their research on both the fasting state and hypocaloric, zero-to-very low carbohydrate diets have made the following observations: First, dietary intake of protein in excess of the usual RDA recommendation will indefinitely postpone the appearance of negative Nitrogen balance in patients following 300-500 kCal per day weight-reducing diets. Prevention of this negative Nitrogen balance will likewise prevent the rapid regain of weight observed after a subject discontinues a total fast and resumes eating even a 500 kCal per day diet. Secondly, these researchers felt that starvation ketosis associated with this sort of low carbohydrate, hypocaloric diet was a harmless and desirable feature of the dietary program. It is harmless because it is unrelated to the pathological condition found in diabetic ketoacidosis, and merely represents an adaptation of the body to the absence of dietary carbohydrate. It is desirable because its appearance coincides precisely with the disappearance of appetite in the subject. The potentially-harmful side-effects of a ketogenic diet, such as the renal organic acid block (in order to preferentially excrete ketone bodies) must be monitored with periodic blood tests, serial ecg tracings and routine administration of 20-40 mEq. potassium per day. The organic acid block mentioned above creates a situation where an elevated serum uric acid occasionally occurs; however, episodes of gout in patients on this diet are not a problem, and these researchers do not recommend routine use of anti-gout medications for patients with serum uric acid levels under 12 mg%. Care must be taken during the reintroduction of carbohydrate-containing foods however, lest the kidney be flooded with urate from the elevated uric acid pool and acute formation of urinary calculi occur.

These researchers did not use predigested collagen amino acid formulas in their research studies. Instead, they used protein foods such as lean beef, fish and poultry as their source of dietary protein. Genuth et al published their clinical experience using a liquid formula feeding composed of a mixture of casein and glucose in treatment of obesity in 1974.³ Subsequently, predigested collagen amino acid liquid formulas containing either zero or trace amounts of carbohydrate began to be manufactured commercially. At first, these products were marketed exclusively to physicians and

pharmacists, but eventually were marketed by every conceivable form of commercial outlet. Finally, the popularity of the book **Last Chance Diet** assured the development of a very profitable market for the use of "the liquid protein diet."⁴ According to Blackburn, these collagen amino acid liquid formulas are a satisfactory source of dietary protein for individuals desiring to follow this sort of weight-reduction diet.⁵

Hazards of Protein-Sparing Modified Fasting

Figure 1 presents a list of potential hazards associated with this method of weight-reduction. The predictability of the occurrence of hypokalemia in these patients make it mandatory for all patients to supplement their dietary effort with 20-40 mEq potassium per day. It is the responsibility of the physician to make certain that patients comply with this regulation by monitoring serum potassium levels periodically. The kaluresis and naturesis associated with such drastic dietary restriction of carbohydrate creates a potential additive effect in hypertensive patients who are on antihypertensive medication. According to Bistrian, the magnitude of this diuretic effect" of the dietary regimen is equivalent to 50 mg. hydrochlorthiazide.⁶

FIGURE 1: Physiologic and Pathophysiologic Effects of Modified Fasting

(Adapted from: Bistrian B.R.: Biochemical and Medical Aspects of a Protein Sparing Modified Fast, Chapter 2, in Obesity, Blackburn, G.L. (Editor), Ctr. for Nutritional Research, Boston, MA, 1977)

1. BLOOD PRESSURE
 - **diuretic drugs:** there is an additive effect in the magnitude of about 50 mg. hydrochlorthiazide; **non-diuretic drugs:** patients taking these drugs should be monitored closely for hypotension.
2. HAIR LOSS
 - is related to the temporary negative Nitrogen balance that occurs during the first one-two weeks on **any** hypocaloric (500 kcal/day or less) diet; it is a transient phenomenon.
3. MENSTRUAL FUNCTION
 - **pregnancy** — ketogenic diets are contraindicated in pregnancy because of the deleterious effect of ketonemia on the fetal brain.
 - **amenorrhea** — morbidly obese (Body Mass Index 42)* and significantly obese (Body Mass Index 27-42) females often experience a normalization of their menstrual cycle when dieting. Mildly obese females often become hypomenorrheic with **any** attempt at weight reduction.
4. INTERCURRENT ILLNESS
 - patients should be careful with the use of syrup vehicles as a hidden source of carbohydrates, as well as the possibility of a reduction in insulin requirements, along with the possibility of digitalis or lithium toxicity.
5. INTERCURRENT ILLNESS
 - myocardial infarction, coronary heart disease and cerebrovascular disease patients should beware of the sudden reduction in blood volume that can accompany the initial diuresis associated with this diet.

* **BODY MASS INDEX**—a term used for comparing degree of obesity among a group of subjects. It is obtained by dividing the square of height into the weight, using metric measurements.

This problem is intensified by the hypovolemia produced during the initial one-two weeks of all low carbohydrate, hypocaloric diets. These observations form the basis of our concern that these predigested collagen amino acid liquid formula preparations should only be used by individuals who are being carefully-instructed and monitored by a physician and pharmacist.

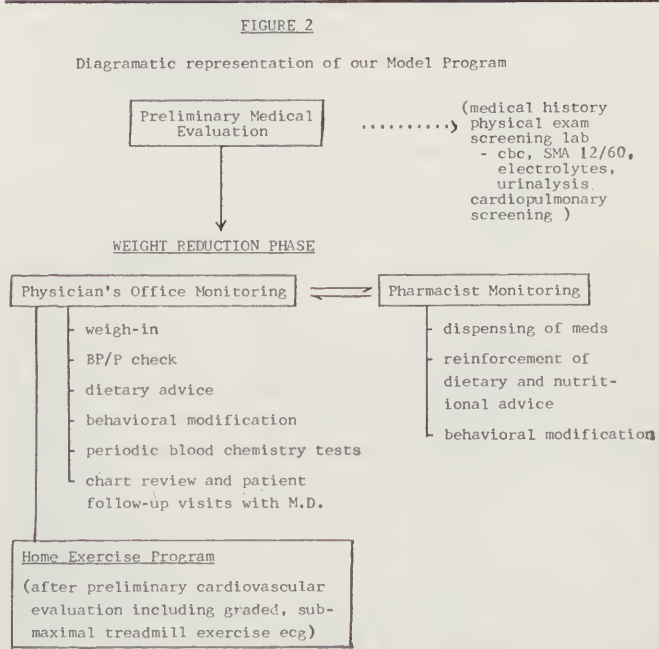
The physician monitors the serum K⁺ by means of periodic electrolyte determinations and monthly ecg tracings, looking for the characteristic electrocardiographic changes associated with hypokalemia. The pharmacist monitors the patient by reinforcing the necessity of them taking their potassium supplementation regularly.

Proposed Model Program

The authors have developed a program designed to administer and monitor an outpatient protein-sparing "modified fast" which fulfills the criteria for safety and effectiveness. The key to this program is that it incorporates the local community pharmacist into the scheme of delivery of this form of health care—in the same manner that the pharmacist interacts with the more traditional forms of health care delivery.

Figure 2 presents our Model Program in diagrammatic fashion. In this model, there is frequent communication between the physician's office and the pharmacist. The pharmacist serves much the same role as the physician's staff in terms of reinforcement of dietary and nutritional instruction. In this physician/pharmacist partnership, the pharmacist supplies an area of expertise that is unfamiliar to most physicians, namely the knowledge of the various brands of vitamin-mineral supplements, etc. In the authors' case, the pharmacist was instrumental in introducing certain types of nutritional supplements to our regimen.

In order to ensure patient compliance in this sort of comprehensive weight-control program, the choice of nutritional agents employed by the physician-



pharmacist team is extremely important. The products utilized should compliment the overall program rather than add to the possibility of treatment failure. It is imperative that the products used should be well-tolerated and accepted by the patient. We have developed a high rate of patient acceptance of our supplements by carefully choosing our manufacturing sources and employing those products which achieve the desired therapeutic effect with a minimum of patient side-effects and complaints.

The authors have personally inspected the manufacturing facilities of our predigested protein supplier. Only the highest quality gelatin is purchased for the manufacture of the liquid amino acid formula used in our program. The predigestion is achieved with the use of natural papaya enzymes. Tryptophane is added to the liquid formula in order to make a biologically-balanced product. A full-time chemist and bacteriologist is employed by the manufacturer in order to assure quality control in each lot of this liquid amino acid formula. We are currently using a carbohydrate and fat-free pineapple-and cherry-flavored liquid formula which has an excellent taste and is well-tolerated by patients' gastrointestinal tracts. The product uses saccharin as an artificial sweetener because sorbital has been observed to induce an excessive amount of gastrointestinal tract symptoms, especially diarrhea in patients attempting to utilize this sort of product as their sole source of dietary protein.

It is estimated that a total dietary intake of 2,000 mg. (55 mEq.) potassium is necessary to avoid hypokalemia while following this ketogenic diet. The amount of potassium supplementation required is determined by the amount of actual food the patient eats. Those following "Plan C" will obtain at least 25 mEq. K⁺ from dietary sources, so another 20 mEq potassium supplementation is appropriate for them. One K-Lyte tablet per day will accomplish this goal. Patients following Plan A and Plan B will require more supplemental potassium. In the interest of economy, we encourage patients to use a generic KCl preparation. Those patients who cannot, for one reason or another, tolerate 60 mEq. per day of the generic KCl liquid, are advised to take two-three tablets per day of K-Lyte. We have also used a complexed potassium supplement which supplies 99 mg. K⁺ per tablet. We have observed no instances of hypokalemia among those patients who follow Plan B or Plan C, but its use is reserved for those patients who cannot even tolerate the K-Lyte.

Vitamin and mineral nutritional supplementation adds to the safety of following such a restricted, hypocaloric diet. We utilize a vitamin-mineral-enzyme preparation, that, along with two Dolomite (calcium and magnesium) tablets daily, will supply the RDA for vitamins and minerals for our patients.

This sort of dietary regimen is obviously deficient in terms of available natural fiber. This would be true even if patients elected to obtain their dietary protein from food sources (beef, fish and poultry) instead of the predigested collagen liquid formula. We

have found that the addition of two tablespoonsful of natural miller's bran daily is effective in preventing constipation in our patients.

Patients who follow our program use certain educational materials⁷⁻⁸ as part of the comprehensive program. Personal responsibility is emphasized by avoiding the use of group sessions for patients. **Figure 3** summarizes the dietary program as it is presented to the patient.

During the first 11 months of 1977, 472 patients began our Model Program. No significant untoward side-effects have been observed thus far in any of our patients. It will take at least a two-year follow-up of these patients in order to determine if our Model Program is any more effective than any other program in terms of inducing long lasting maintenance of attained weight-loss; however, in an effort to evaluate short-term results in patients following our Model Program, we compared the weight-loss among the 30 subjects who started our Model Program during the month of July, 1977 with a similar group of 25 subjects who attempted to follow a similar, although less sophisticated weight-reduction program beginning in July, 1976.

Both groups of patients were followed from July 1st-Sept. 30th of their respective years. **Figure 4** summarizes

FIGURE 3: The Author's Protein-Sparing Hypocaloric Diet Regimen

1. **Preliminary Medical Screening**
 - A. History
 - B. Physical Examination
 - C. Laboratory Tests (cbc, urinalysis, SMA 12/60 and electrolytes)
 - D. Assessment of Cardiorespiratory Status
 - resting ecg
 - graded, multistage treadmill Exercise ECG
 - pulmonary function testing
2. **Dietary Regimen**
 - the goal of the diet is to furnish approximately 1.5 Gram protein/kg ideal body weight per day **and** to restrict dietary carbohydrate to less than 20 Grams per day.
 - The patient is given the choice of one of three "plans":
 - Plan A:** 1.5 G amino acid formula/kg ideal body wt.
 - Plan B:** 0.75 G amino acid formula/kg ideal body wt. + one "meal" consisting of 6 oz. lean beef, fish or poultry.
 - Plan C:** 10-14 oz. lean beef, fish or poultry divided into 2-3 feedings. No amino acid formula is used at with Plan C.
 - + raw vegetables (low carbohydrate) in small quantity.
 - + at least 1 quart non-caloric liquid per day.
 - + multiple vitamins and minerals including potassium, folic acid, calcium and magnesium.
3. **Monitoring of the Patient**
 - weekly office visit for weighing, dietary advice and low key behavioral modification.
 - use of a special textbook/manual*
 - encouragement in beginning a special home-study program in exercise and physical fitness.*

* information concerning these manuals can be obtained from the author.

FIGURE 4: Summary of comparison of weight-loss attained by 30 Model Program subjects and 25 subjects attempting to follow a weight-reduction regimen in 1976.

1976 Patients (7/1-9/30/76)		1977 Model Program (7/1-9/30)	
25	Number Starting	30	
(all female)		2 male; 28 female)	
36.7 years	Mean Age	36.5 years	
6.8 lbs.	Mean Weight-Loss	11.9 lbs.	
Age Distribution			
2	less than 20	2	
6	20-29	5	
8	30-39	12	
		(1 male)	
5	40-49	8	
		(1 male)	
4	50-59	3	
Distribution of Weight-Loss			
3	Gained Weight	1	
9	0-5.75 lbs. Lost	6	
6	6-9.75 lbs. Lost	8	
5	10-14.75 lbs. Lost	7	
0	15-19.75 lbs. Lost	5	
1	20-24.75 lbs. Lost	4	
1	25-29.75 lbs. Lost	2	
0	30+ lbs. Lost	1	

the results of these two comparable groups of subjects. The mean weight-loss of 11.9 lbs. for the 1977 Model Program subjects, (with a mean weight loss of 13.6 lbs. for those who attempted to participate in the home exercise program) compared to the mean weight-loss of 6.8 lbs. for the 1976 group of subjects speaks for itself regarding the effectiveness of our program.

Conclusions

The authors have researched, developed and implemented a comprehensive weight-reduction program that utilizes predigested, collagen amino acid formula feeding in a safe and effective manner. By prescribing one specific laboratory-tested brand of liquid formula, we have reduced the likelihood of untoward reaction. At the same time, we were able to encourage compliance by patients engaged in the use of this potentially-hazardous method of weight-reduction.

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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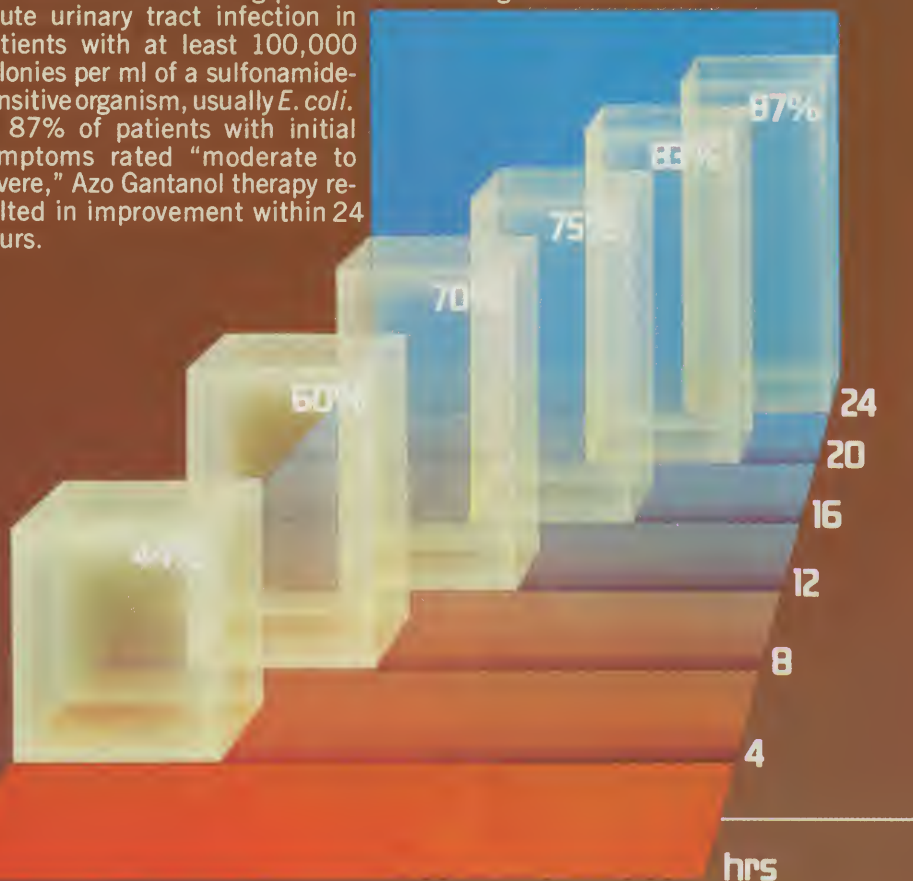
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Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists causes other than infection should be sought. After relief of pain has been obtained, continue treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



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A Sketch of the History of Obstetrics and Gynecology in Maryland, 1770-1976

By JOHN E. SAVAGE, MD

This paper was presented in part at the Mid-Year Meeting of the American Association of Obstetricians and Gynecologists on Apr. 29, 1977, at Baltimore, MD. For reprint and other data, write Dr. Savage at RD #4, Box 204, Cambridge, MD 21613.

Obstetrics as an art and science received scant attention from the early colonists. It was not until the middle of the 18th Century that medical men either in Europe or the English Colonies began to accord it a place in the practice of medicine and assumed any considerable responsibility. Up to then, midwives were largely in control of the practice of Obstetrics.

In 1774, a Mrs. C. G. Reiman advertised, "That having qualified as a midwife, she hopes, in so prolific a town as Baltimore, to get patronage." Her hopes may have been well-founded, for the population of the Province of Maryland was said to have been between 200,000-300,000, and in Baltimore 5,900. An added factor was that there were recorded only 10 physicians in the city on that date.

By 1800, gynecology had not even begun to be a separate subject, even though Lotichius, of Frankfurt, in the 17th Century first used the word in his dissertation entitled *Gynaecologia*. Physicians in the provinces maintained their versatility by practicing general medicine and surgery, which in many instances embraced gynecology and obstetrics.

At mid-18th Century, physicians treated symptoms rather than diseases, and the clinical thermometer, hypodermic syringe and stethoscope were not yet available to them.

1770 - 1800

The period from 1770 - 1800 encompassed the American Revolution and its aftermath. In 1776, the Congress assembled in Baltimore. Physicians in Maryland played prominent roles in manufacturing salt-petre, became surgeons in the military, helped provide arms, passed quarantine laws, combatted various epidemics and treated victims of natural disasters such as the hurricane of 1788. Several local medical societies were organized, mainly to help restrict the practice of medicine to those duly-qualified, in order to eliminate quackery. The plan and actions of the Medical Society of Baltimore in 1788 apparently laid the foundations for the charter of the Medical and Chirurgical Faculty of Maryland, which was incorporated in 1799.

George Buchanan studied under William Shippen of Philadelphia and served with him in the Revolution. He lectured to a class of nine students in Baltimore in the winter of 1789-90 on diseases of women and children, and was a founder of the Medical and Chirurgical Faculty of Maryland. In the same year, Andrew Wie-

senthal lectured in his home to 15 students on a variety of topics, one of which was the gravid uterus, and in 1797 lectured on midwifery.

The year 1796 marked the incorporation of the City of Baltimore, and the arrival from abroad of John Beale Davidge. The latter began lectures in his home in 1802 on a number of subjects, including midwifery. When the College of Medicine of Maryland was established by an act of the Legislature in 1807, he was one of the founders and became the first Professor of Obstetrics and the first Dean. The University of Maryland thus came into being and, according to Williams, was the fifth such school to be founded in this country. Of these five schools Williams wrote in 1903, "These schools have pursued an uninterrupted existence, continuing to the present day, and should be regarded as the pioneers in medical education in this country."

1800 - 50

Baltimore Town at the close of the 19th Century and the beginning of the 19th was described as the geographic center of the Republic. With world trade controlled by Great Britain and the United States because of war in Europe, Baltimore shared in the general prosperity. Tobacco, corn, wheat and flour were the important staple exports. Shipbuilders produced the *Baltimore Clippers* which became world famous as the fastest commercial vessels afloat.

John Archer of Harford County was the recipient of the first medical diploma issued in America on June 21, 1768 from the College of Medicine of Philadelphia (united with the University of Pennsylvania in 1791). He made a number of contributions to obstetrical literature, beginning in 1810, in the early numbers of the *Medical Repository*. He also was one of the founders of the Medical and Chirurgical Faculty, and served in the Army during the Revolution.

Although he never performed the operation, James Cocke, a partner in practice of John B. Davidge and a founder with him of the College of Medicine of Maryland, defended the practicability and propriety of ovariectomy in a thesis in 1804. Ephriam McDowell successfully performed ovariectomy by abdominal section in 1809 in Kentucky. He was again successful in 1813 and 1816, and a number of times subsequently. He was given an honorary degree by the University of Maryland School of Medicine in 1825.

Horatio G. Jameson, MD (Univ. of MD, 1813) is said to have been the first in Baltimore in 1824 to attempt ovariectomy, and the first in America to excise the cervix uteri.

In 1835, and again in 1838, William Gibson, Professor of Surgery at the University of Maryland, performed

successfully Caesarean sections on the same patient. This was one of the earliest instances in this country of this having been done.

Thoms states that one of the major contributions of an American to obstetrics was the introduction in 1807 of ergot into clinical obstetrics by John Stearns of Massachusetts. According to Williams, Pierre Chatard, who settled in Baltimore about 1800, was the most distinguished early obstetrician in Maryland. In 1820 and 1821, he published the results of his experiments with ergot. These record some of the earliest clinical trials of ergot in America. Chatard approved of its use when "the parts are dilated and there is mere inertia of the womb." From about 1800 until he died in 1848, he delivered 4,309 patients in his private practice and left fairly full notes of all his cases. These notes were published by his son-in-law, W. C. Van Bibber, MD (Univ. of MD, 1845). The work of these and other pioneers ultimately led to the development of modern oxytocic drugs. Professor M. S. Karasch, at the University of Maryland, College Park, and Professor M. R. Thompson of the University of Maryland School of Pharmacy were two of the four investigators who, in 1935, independently and almost simultaneously isolated the alkaloid of ergot which produced the prolonged action of the uterus most useful in obstetrics. Ergonovine was the name given this compound. It has now been synthesized, but the naturally-occurring alkaloid is the source of almost all of this oxytocic drug now used in this country.

The Baltimore Infirmary was completed and occupied in 1823. It is believed that here for the first time in this country medical students benefitted by intramural residency training. There were four subsequent additions to this building, which became the University of Maryland Hospital.

John Fonerden, MD (Univ. of MD, 1823) was Professor of Obstetrics and Diseases of Women and Children at Washington Medical University of Baltimore. He was the first Librarian, then Secretary, then President of the Medical and Chirurgical Faculty of Maryland. It has been written that he was the personal physician and friend of Johns Hopkins, who appointed him a trustee of both his Hospital and his University.

The first session of the American Medical Association convened in Baltimore in 1848, with 21 delegates from the Medical and Chirurgical Faculty and five from the Medical and Surgical Society of Baltimore present. In that same year, John Murphy is said to have performed the first successful ovariectomy in Baltimore.

1850 - 1900

One of the most fundamental and far-reaching medical contributions in its ultimate effect came with the publication in 1853 by Francis Donaldson, MD (Univ. of MD, 1846) in his paper entitled, *The Practical Application of the Microscope to the Diagnosis of Cancer*. In 1866, he became Professor of Physiology and Hygiene at the University of Maryland. He is said to have been the first person in this country to take biopsies and with the aid of a microscope make the diagnosis of cancer.

Unfortunately, his discovery remained unused for a number of years. With the increasing use of the microscope, much basic work evolved in all fields of medicine, including obstetrics and gynecology. As an example, we point to the establishment of the entity of carcinoma in-situ of the cervix beginning with the publication in 1900 by Thomas S. Cullen of Baltimore of his book entitled, *Cancer of the Uterus*. In this work appeared the first recorded histologic picture of carcinoma in-situ of the cervix; however, it is said that Cullen was unaware of its significance. Others subsequently built further on this concept, which will be elaborated upon later in this account.

Professor Edward Warren of the University of Maryland in 1856 published a prize essay entitled *On the Influence of Pregnancy on the Progress of Phthisis*. More and more papers on subjects in both obstetrics and gynecology began to be published, among which were a report on the introduction of an unfenestrated forceps and a new pessary for the treatment of procidentia uteri.

The first chair of the Disease of Women and Children in the US was established at the University of Maryland in 1867 with the appointment of Professor William T. Howard to that post. He and Henry P. C. Wilson are recognized as the co-founders of the former Hospital for Women of Maryland. Wilson for some years was believed to have been the only pure obstetrician-gynecologist in Baltimore. He was first in Maryland to remove the uterine appendages by abdominal section, and the second to perform ovariectomy successfully. He was a prolific writer on obstetrical and gynecological subjects. Kelly stated that Wilson was practically the founder of gynecology in Maryland. Howard and Wilson were among the founders of the American Gynecological Society.

Randolph Winslow, Professor of Surgery at the University of Maryland, is credited with being the first in Maryland to have shortened the uterine ligaments (1884), and to have performed vaginal hysterectomy (1888). Thomas A. Ashby, Professor of Obstetrics at the University of Maryland, is said to have performed the first successful laparotomy for ruptured tubal pregnancy in 1880.

Interest in pain relief during childbirth became evident with the publication of treatises on the subject. George W. Miltenberger became Professor of Obstetrics at the University of Maryland in 1858, after having been Dean since 1855. He published a paper in that year entitled *Chloroform in Obstetrics*. He was appointed consulting physician to the Johns Hopkins Hospital upon its opening in 1889. W. J. C. Du-Hamel, MD (Univ. of MD, 1849) in 1870 wrote *On Chloral Hydrate as an Anesthetic in Parturition*, which is thought to have been the first employment of this drug for this purpose in America. He also wrote on Chloroform. Thomas S. Latimer, MD (Univ. of MD, 1861), wrote the first paper in Baltimore on anesthesia in midwifery.

Emphasis on the care of women has been limited to the recent 20th Century. The Maternité, or Lying-in Hospital in Baltimore, was founded in 1874, and

Thomas Opie, Professor of Obstetrics and Dean of the College of Physicians and Surgeons of Baltimore, was the attending obstetrician. (He was one of the Founding Fellows of the American Association of Obstetricians and Gynecologist in 1888.) Under the auspices of the same school, the Maryland Woman's Hospital was founded in 1878. The Woman's Medical College of Baltimore, the first medical college exclusively for women in the South, and either the fourth or fifth in the US, was chartered in 1882. In the same year, the Hospital for the Women of Maryland was founded by Henry P. C. Wilson and William T. Howard. A Free Lying-in Hospital was established in 1887, in the vicinity of the University Hospital, and was under the direction of the Professor and the Demonstrator of Obstetrics. The medical students of the University there were afforded clinical experience in obstetrics, which seems to have been the first serious attempt at practical instruction.

In 1879 and 1880, Henry P. C. Wilson successfully accomplished two operations unusual in that era. He removed an ovarian tumor in the fourth month of pregnancy from a patient whose pregnancy had been diagnosed prior to operation, and who was delivered at term of a healthy child. He also achieved a notable result when operating upon a patient who had a twin pregnancy, one extrauterine and the other intrauterine. The extrauterine child was removed alive and the intrauterine child was delivered naturally.

In spite of the growing number of medical schools (at least six) and hospitals devoted to the care of women, the obstetrical situation in Baltimore appears not to have been in a desirable condition in the late 1880s. Most of the so-called lying-in hospitals were small, poorly-managed and equipped, and were without adequate medical supervision or nursing. Hospitalization of obstetrical patients had not become popular. Prenatal care was generally nonexistent. Antiseptic technique was imperfect, and infection was frequent. Eclampsia, accouchement force, craniotomy and pelvic deformities due to rickets were common, and Caesarean section was resorted to infrequently; however, in the early 1890s, the hospital situation began to improve. Better organization and teaching by qualified and experienced physicians seems to have brought about this betterment in practice, together with the successful establishment of the carefully-supervised "Outdoor Clinic" at the University. Leonard E. Neale became Professor of Obstetrics at the University of Maryland in 1896. In the opinion of Rowland, Neale was probably better qualified as a clinical obstetrical teacher and practitioner than any other man then present in Baltimore or any who had preceded him.

In 1889, the new Johns Hopkins Hospital was opened with Howard A. Kelly as Gynecologist-Obstetrician and Professor of Gynecology and Obstetrics; however, no obstetrical patients were admitted until 1896. The first class of students entered the Johns Hopkins University School of Medicine in 1893. The teaching of obstetrics was begun in 1894, and was entirely under the direction of J. Whitridge Williams. George W. Dobbin joined Williams in teaching in 1896, and retained this

position until 1901, when he was elected Professor of Obstetrics at the College of Physicians and Surgeons of Baltimore.

Howard A. Kelly in 1889 accepted the Professorship of Obstetrics and Gynecology in the Johns Hopkins University, and the Directorship of these Departments in the hospital. He held the academic title of Professor of Obstetrics and Gynecology throughout his tenure, but neither practiced nor taught obstetrics. As a world-renowned gynecologist, he pioneered in the development of female urology, which became an integral part of his Department. He developed the technique of air cystoscopy with catheterization of the female ureters under direct vision. He invented instruments and created operative procedures which bear his name. Harvey has said that Kelly "Did more to establish American gynecology as a surgical specialty than anyone before or since his generation." Adding Max Brodel to his staff in 1893 ultimately led to the creation of the Department of Art as applied to medicine, of which Brodel became the first Director. Kelly produced many books and papers on subjects in his field, as well as in the fields of natural history and medical biography. One of his hobbies was herpetology. He was President of the American Gynecological Society in 1912, and was a fellow of almost countless other societies (medical and natural history) both American and foreign. He was a teacher, a scientist, a most skillful surgeon, a philanthropist and was deeply religious.

1900 - 76

In writing of obstetrics and gynecology in Maryland in the 20th Century, it is impossible to include all who have made noteworthy contributions. The writer regrets the necessity for this limitation, which is made in deference to a semblance of brevity. Consequently, the material in this period, for the most part, is presented as "thumb-nail" sketches, many of which are those of past and present department heads at the two medical schools in Baltimore.

William S. Gardner, MD (P. and S., 1885), successively at the College of Physicians and Surgeons of Baltimore, was Demonstrator of Obstetrics and Chief of the Outdoor Obstetrics Department and Associate Professor, then Professor of Gynecology. In 1915, he was appointed Professor of Gynecology at the University of Maryland and Gynecologist-in-Chief at the University Hospital. He held this position until his retirement in 1935, when he became Emeritus Professor. In 1921, he was elected President of the Medical and Chirurgical Faculty. Gardner was a meticulous technician and devised a number of original techniques.

James M. H. Rowland was graduated from the Baltimore Medical College in 1892, fourth in a class of 81. In 1900, he was appointed Chief Physician at the Maryland Lying-in Hospital. Elected Dean of the School of Medicine of the University of Maryland in 1916, in 1920 he became Professor of Obstetrics. Both of these positions he held until his retirement in 1939. He was elected President of the Faculty in 1931, and served as Vice President for one year of the Association of

American Medical Colleges. He was instrumental in creating state laws governing the activities of midwives, which together with important medical advances had an ultimate effect in reducing maternal and infant morbidity and mortality.

Rowland was an early advocate of episiotomy in primigravidas before overdilatation of the perineum occurred, as a means of preventing fetal intracranial trauma, and subsequent maternal perineal relaxation. In spite of vigorous disagreement by some of his prominent colleagues in the obstetrical world, he taught and practiced Caesarean section in the treatment of certain types of placenta previa in preference to some of the traumatic methods then in vogue, such as accouchement force and Braxton-Hicks bipolar version. Time has more than vindicated his position. It is believed that Rowland's most important contribution was in the teaching of clinical obstetrics, where he excelled in lectures, clinics and rounds presented with great respect for facts and common sense.

Emil Novak at 20 years of age graduated magna cum laude in 1904 from the Baltimore Medical College (merged with the University of Maryland). In addition to a large private practice, he taught at both University and Hopkins. In 1941, he published his two best-known books, *Gynecological and Obstetrical Pathology*, and *Textbook of Gynecology*. Both of these works have been perpetuated in regularly-revised editions by the author, followed by Edmund R. Novak, J. Donald Woodruff and Howard and Georgeanna Jones. Novak was the author of over 300 articles and four books. He became the first chairman of *The Ovarian Tumor Registry* in 1942. With Nicholson J. Eastman in 1946, he inaugurated the *Obstetrical and Gynecological Survey*, a bi-monthly journal of abstracts with editorial comment. This publication has continuously retained its popularity to this day. In 1947, he became the first Chairman of the *Chorionepithelioma Registry*, and was elected President of the American Gynecological Society. He was recognized throughout the world to have been the foremost authority in the field of gynecological pathology. He was a fellow of the American Association of Obstetricians and Gynecologists, and a member of many other societies and an honorary fellow of a number of foreign associations.

The Johns Hopkins University School of Medicine awarded J. Mason Hundley, Jr., the MD degree in 1916. After an internship and assistant residency at the former Union Protestant Infirmary, now Union Memorial Hospital, he served overseas with a mobile operating unit and an evacuation hospital from July, 1918–May, 1919. Upon his return to Baltimore, he was assistant resident and resident in gynecology at the University Hospital from 1919 through 1921. His chief was his father, J. Mason Hundley, who was Professor of Gynecology at that time. From associate in gynecology in 1921, he rose progressively until 1935, when he was appointed Professor of Gynecology and Head of the Department at the University of Maryland School of Medicine. Upon his retirement in 1955, he was made Emeritus Professor.

Hundley initiated and developed the Department of Oncology at the University Hospital with Grant E. Ward, and created the Division of Female Urology. His many publications reflected his special interest in female urology, pelvic cancer, radiation therapy of pelvic malignancies and ovarian tumors. He was a fellow of the American Gynecological Society, the American Association of Obstetricians and Gynecologists, the American Urological Association and the Southern Surgical Association. He organized the Maryland Division of the American Cancer Society and was Chairman of its Executive Board for 11 years.

Succeeding J. M. H. Rowland, Louis H. Douglass, MD (Univ. of MD, 1911) became Professor of Obstetrics and Obstetrician-in-Chief at University Hospital in 1938. When Baltimore City Hospitals expanded, he organized the obstetrical department and became the first Obstetrician-in-Chief in 1934. The service was the largest in the city for a number of years. With Douglass and Nicholson J. Eastman as Co-Chairmen in 1935, the Maryland State Maternal Mortality Committee was formalized, it being the sixth in the US in order of organization. In 1951, Douglass was one of the 13 original members, a Director and the first First Vice President of the American Academy of Obstetrics and Gynecology, which became the American College of Obstetricians and Gynecologists. Douglass was one of the founders and the first President of the Baltimore Rh Typing Laboratory, Inc., which was one of the earliest and best-known in its field. From his internship to his retirement in 1955, he served the University for 44 years, except for the period from June, 1917–to October, 1919, when he was with the US Marines as a member of the US Navy Medical Corps Reserve.

Upon the retirement in 1955 of Louis H. Douglass as Professor of Obstetrics, and J. Mason Hundley, Jr., as Professor of Gynecology, Arthur L. Haskins, Jr., was named Professor of Obstetrics and Gynecology in the University of Maryland School of Medicine, and Obstetrician-Gynecologist-in-Chief at University Hospital. This was the first time in the history of medical education in Maryland that those two specialties were combined in one Department. Haskins came to the University from Washington University School of Medicine, in St. Louis, MO. He has contributed extensively to the literature of endocrinology and infertility. Among his many professional memberships, he is a fellow of the American Association of Obstetricians and Gynecologists.

During his time, J. Whitridge Williams, MD (Univ. of MD, 1888) became not only the outstanding obstetrical figure in Baltimore, but also one of the two or three prominent men in the country. In 1899, he became Professor of Obstetrics at Johns Hopkins University School of Medicine, and Obstetrician-in-Chief of the Hospital. In 1919, he held these positions as the head of the first fulltime Department of Obstetrics in this country. When he was elected to fellowship in the American Gynecological Society, he was the youngest member ever admitted, and in 1914 he served as its President.

The first edition of Williams' Textbook, *Obstetrics*, appeared in 1903, and through many subsequent editions, it has remained one of the most popular texts in the field. In addition to his text, he contributed a total of 120 papers to the literature. Starting in 1900, and for the following 30 years, Williams wrote 15 monographs on different phases of placentation, and thus became the authority of his era in that field. In addition to his departmental responsibilities he was Dean of the medical school from 1911-1923, a position, it is said, he held with distinction. In 1916, he was elected President of the Medical and Chirurgical Faculty. Among his papers were those relating to the effect of contracted pelves on dystocia, especially the studies demonstrating the funnel pelvis as a common cause, and a monograph on spondylolisthesis, pathology of the placenta and premature separation, toxemias of pregnancy, hydatidiform mole and chorionepithelioma, prevention of fetal syphilis and pelvic pathology.



Upon the retirement of Howard Kelly in 1919, Thomas S. Cullen was appointed Professor of Clinical Gynecology and Head of the Department of Gynecology. He served in these positions until he retired in 1939. In addition to the book, *Cancer of the Uterus*, his writings included topics in gynecological pathology, pelvic diagnosis, medical history and bibliography. Cullen was elected President of the Faculty in 1927. Senior members of his staff during his tenure, all of whom were parttime, were Guy L. Hunner, Edward H. Richardson, Sr., Emil Novak and Dewitt B. Casler. Cullen established the Gynecological Pathology Laboratory at the Hospital.

In 1939, Richard W. TeLinde was appointed Professor and Head of the Department of Gynecology and Gynecologist-in-Chief of the Johns Hopkins Hospital. In 1956, he became fulltime, and for the first time in the history of Hopkins, every department of the school was on a fulltime status. He is a firm believer in the long-term residency system. His publications number over 100, and his magnum opus is the popular text, *Operative Gynecology*, which continues in updated editions. His chief interests include carcinoma in-situ of the cervix, female urology with special emphasis on urinary incontinence, endometriosis and gynecological pathology in general. His memberships include the American Gynecological Society, of which he was President in 1953; the American Gynecological Club, of which he was President in 1949; Southern Surgical Society; Society of Pelvic Surgeons and honorary fellowship in many foreign societies. TeLinde is widely recognized as a preeminent surgeon and an inspiring teacher and lecturer. Presently, he is Professor of Gynecology Emeritus, and has established a professorial chair in gynecological pathology. This endowment also will be used to help maintain the Gynecological Pathology Laboratory. J. Donald Woodruff is the first Richard W. TeLinde Professor of Gynecologic Pathology.

Building on the previously-mentioned work of Donaldson in 1853, and Cullen in 1900, Baltimore physi-

cians have played an important role in developing the means of early detection of cancer of the cervix, and also in cancer research. Richard W. TeLinde and Gerald A. Galvin at Hopkins established the histologic criteria for the diagnosis of carcinoma in-situ of the cervix. In 1952, Galvin, Howard W. Jones, Jr. and TeLinde published their classic paper, *Clinical Relationship of Carcinoma in-Situ and Invasive Carcinoma*. In addition, screening by cytology and biopsy when indicated have become recognized techniques for early diagnosis. George O. Gey, also at Hopkins, became the first to culture and grow carcinoma of the cervix cells, and thus founded the cell line ("HeLa") which now has been kept alive over 25 years. These cells have contributed immensely to studies in molecular and cell biology; however, recent developments have shown that many of the established cell lines in the American Type Culture Collection are believed to be "HeLa" contaminated. This has been a heavy blow to many investigators, who now realize that their careful laboratory methods must be even more meticulous.

Upon the death of J. Whitridge Williams in 1931, John McF. Bergland, a parttime member of the staff at Hopkins, who also taught at the University of Maryland, was appointed Acting Director of the Department of Obstetrics and Obstetrician-in-Chief of the Hospital. He was one of the leading practicing obstetricians in Baltimore with an extensive practice.

In 1935, Nicholson J. Eastman was elected Professor of Obstetrics and Obstetrician-in-Chief of the Johns Hopkins Hospital. With Richard TeLinde, he continued the tradition of separate Departments of obstetrics and gynecology. His interests were worldwide, as evidenced by his election to the Chairmanship of the Committee on Maternity Care, and the Committee on Midwifery Training of the World Health Organization (WHO.) One of Eastman's primary interests was that of the role of obstetric factors in the causation of cerebral palsy and neuropsychiatric conditions. He was President of the American Academy of Cerebral Palsy in 1957. His series of reports, entitled *Fetal Blood Studies*, established him as one of the pioneers in clinical research in the field of reproductive medicine, and he was considered by many to have been a founder of perinatal medicine. He was President of the American Association of Obstetricians and Gynecologists in 1953, where he gave his Presidential Address, *Mount Everest in Utero*. This now is considered a classic in the study of the environmental relationships of the mother and fetus. He was President of the American College of Obstetricians and Gynecologists in 1962, and President of the American Gynecological Society in 1964. He had a deep interest in forensic obstetrics. He edited three editions of *Williams Obstetrics*, and was a founding editor with Emil Novak in 1946, of *The Obstetrical and Gynecological Survey*.

The Departments of gynecology and obstetrics at Hopkins, like those at Maryland, had been separate from their inception, were combined in 1960 under Allan C. Barnes, who became the first Professor and Director of the Department of Gynecology and Obstetrics, Johns Hopkins University School of Medicine

and Gynecologist-Obstetrician-in-Chief of the Johns Hopkins Hospital. Previously, he had been Professor and Chairman of the Departments of Obstetrics and Gynecology at Ohio State University College of Medicine, and Western Reserve University School of Medicine, respectively. In 1970, he resigned his position at Hopkins to become Vice President for Biomedical Affairs of the Rockefeller Foundation. Barnes is a member of numerous national and international organizations. He has served as Chairman of the Obstetrics and Gynecology Advisory Committee of the Food and Drug Administration (FDA.) He has written on many and diverse subjects in the field. His paper, *Body Production of ACTH in Response to Gynecologic Surgery and Irradiation*, received the 1952 Foundation Award for gynecologic research of the American Association of Obstetricians and Gynecologists. He was a member of the Advisory Panel on Maternal and Child Health of the World Health Organization. He is Editor Emeritus of the *American Journal of Obstetrics and Gynecology*.

In the period from June, 1970 until November, 1971, Howard W. Jones, Jr., was Acting Chairman of the Department of Gynecology and Obstetrics at Hopkins. He, with Georgeanna Seegar Jones, both of whom are Professors of Gynecology and Obstetrics, are Co-Editors-in-Chief for Gynecology of *The Obstetrical and Gynecological Survey*. They are eminent authorities in the field of reproductive endocrinology, and are greatly in demand as speakers, both in this country and abroad.

Theodore M. King became Professor and Director, Department of Gynecology and Obstetrics of the Johns Hopkins University School of Medicine and Gynecologist-Obstetrician-in-Chief of the hospital in November, 1971. He was called to this post from the Albany Medical College, where he had been Chairman of the Department of Obstetrics and Gynecology from 1968. He has conducted extensive research in the fields of reproductive pharmacology and fertility control. Among his fellowships are those in the American Gynecological Society and the American Association of Obstetricians and Gynecologists. Currently, he is Chairman of the Advisory Committee on Obstetrics and Gynecology of the Food and Drug Administration, and a member of the Advisory Committee in Obstetrics and Gynecology for the US Pharmacopeia.

Epilogue

C. V. Wedgewood has written: "History is lived forwards, but it is written in retrospect. We know the end before we consider the beginning, and we can never wholly recapture what it was to know the beginning."

Acknowledgments

The author expresses his sincere thanks to Miss Hilda E. Moore, Librarian Emeritus, and her staff at the Health Sciences Library of the University of Maryland for their kind assistance in providing reference materials. Appreciation also is expressed to Howard W. Jones, Jr., and Theodore M. King for their invaluable aid.

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TWO SYMBOLS OF THE "WORLD PORT OF BALTIMORE": (nautical) The USS **Constellation** and (medical) Dr. John B. MacGibbon (inset.)

Baltimore's "Port Doctor:" An Exclusive JOURNAL Interview With John Butler MacGibbon, MD

By BLAINE TAYLOR

Contact Mr. Taylor, *Journal* Managing Editor, for reprint and other data c/o the *Journal*, 1211 Cathedral St., Balto., MD 21201.

Introduction: A Unique Practice

This physician is a man with a unique medical practice: foreign merchant seamen. As Baltimore's "port doctor" for the last two decades, John Butler MacGibbon, MD, 57, has treated literally thousands upon thousands of sailors from all over the world from ocean-going vessels which daily arrive at—and leave—the "world port of Baltimore," formerly home of the famed Baltimore Clipper ships and currently host to the USS *Constellation*, the submarine *Torsk*, the Maryland Sea Service Cadets and the new World Trade Center Baltimore.

Dr. MacGibbon—a soft-spoken, pleasant, ruddy-faced man with graying hair and a friendly smile—is, like his patients, a foreigner. Although a resident of the United States since he first arrived in 1950, the internal and occupational medicine practitioner still retains the citizenship of his native New Zealand, where he was born at Christchurch on Nov. 24, 1921.

The single physician—who resides in Baltimore's suburban Northwood section—has had his practice headquartered for the last seven years in an office at 800 Cathedral St. downtown, four blocks south of the Faculty Building of Med-Chi (of which he has been a member since 1955.) Before that, his office was located since 1959 near the US Customs House at Gay and Lombard Sts., adjacent to the harbor. (It was in the Cathedral St. office that he was interviewed by the *Journal* on June 7, 1979.)

The man whose hobbies include music, swimming and reading (biographies, plus a smattering of fiction) has current appointments as Physician to the Outpatient Department (Moore Clinic) and as an Instructor in Medicine at the Johns Hopkins University School of Medicine, and it was to Hopkins that he turns for relief physicians to hold down his unusual practice when he goes on vacation—usually for three weeks and often to New Zealand, where he performed a Rotating Internship at Christchurch City Hospital during 1948-50, before serving a year's Residency at Baltimore's Church Home and Hospital.

Between 1951-54, Dr. MacGibbon served a fulltime fellowship in medicine at Hopkins, returning for a year's Chief Residency at Church Home in 1954. The following year saw him at the University of Maryland, and he served during 1956-58 as Assistant to the Chief of Medicine of the US Naval Hospital at Portsmouth, NH. From 1957-62, Dr. MacGibbon was a Lieutenant Commander in the US Naval Reserve.

He began his private practice in 1959, and is on the staffs of Church Home, Union Memorial and South

Baltimore General Hospitals. A member of the AMA, the Baltimore City Medical Society; the British, New Zealand and Southern Medical Associations; the Hopkins Medical and Surgical Association and the Maryland Society for Rheumatic Diseases, Dr. MacGibbon's publications include *Treatment of Tuberculosis Meningitis* (*New Zealand Medical Journal*), 1950; *Anaphylactic Reaction to Penicillin* (*British Medical Journal*) and *Neurological Complications of Serum Administration* (*American Journal of Medical Sciences*.)

The year 1959 also witnessed his appointment as Physician to the Norwegian Consulate-Public Health Service Directorate for Seamen, and, since 1965, he has been Public Health Physician to the Italian Cassa Maritima (Marine Fund) and holds similar posts as Contract Physician to the US Quarantine Service and the Swedish Merchant Marine as well. It was Dr. MacGibbon's unusual practice that led the *Journal* to seek him out to discuss his life's work caring for the men who ply the world's oceans.

US Advent

Why did you decide to come to the US?

I had a Fulbright scholarship and an uncle who was a great friend of some of the people in the Hopkins medical unit—specifically Dr. Amos Koontz—which was located at Auckland during World War II.

How did you—from among all the literally thousands of physicians in Baltimore—get selected to do this work with seamen?

I worked for an industrial clinic in town part-time when I was a Resident. When I started out in practice, the clinic handled a lot of this sort of work besides its Workmen's Compensation work. I became friendly with the Norwegian Life Consul at the time, who was a patient of mine, and he asked me if I'd like to take care of their work. I said yes because their doctor had retired and they weren't too happy about having their people go to a large clinic where there wasn't much personal interest in each person as far as following things up was concerned, because they had different doctors all the time.

I took up the practice and it just grew over the years. I've always been interested in ships and the water. As a medical student, I used to spend my vacations working as a longshoreman. As a boy in New Zealand, there was no place there that was more than about 90 miles away from the water. Some years ago, at Annapolis, I used to have a sailboat, too, but I don't now.

"The Port Doctor"

Is it accurate to characterize you as "the port doctor?"

Yes, because I don't know anybody else who does

this work, except for people like Central Medical and Eastern Industrial, which are groups of doctors that examine American crews before sending them out. They also do a lot of work with Workmen's Compensation.

His Work

Please give our readers an overview of the work you do for the various sailors' agencies. I imagine that it all ties-in, right?

Yes. Really, there's no contact with the governments, as it's not a governmental thing. The appointment was originally through the Norwegian Public Health Service, which approves of doctors at various ports throughout the world. The work's done through the local ship's agents and through the insurance companies which insure these people for their health and against accidents. The work occasionally involves going onto the ships to see people who're sick, but, mostly, I see the seamen here in my office.

Aside from my major appointments, the Greeks, Pakistanis, Chinese and Indians are mostly insured by the Protective and Indemnity clubs, which are insurance groups that insure against health and accidents for the sailors and against accidents to the ships, too. Most of them are located in London, and most of their people come here to me, also.

When a ship comes in, it rarely calls ahead. After the ship docks and is cleared by Immigration and Customs, they'll call one of the port service people to pick up the seamen and bring them here at a certain time, ideally, but, in practice, this never happens—they're always an hour or two late. They "had to go to the bank" or "shopping" or whatever, so you never know exactly when anybody is coming. Also, I never know if it's going to be one or 15! They arrive with company forms that have to be filled out, too.

Many times, ships are in from Japan and Australia after a month's voyage, and in port for only about eight hours. The sailors will sometimes use "going to the doctor" as an excuse for going ashore for some shopping, and I suppose you can't blame them, really.

How many seamen patients do you treat in an average year?

About 12 a day.

What do they come in for—general physicals and check-ups?

Sometimes for those and illnesses; often for venereal disease inoculations and vaccinations. I have a small private practice, too, and I see my private patients between 8:30-10 AM, or late in the afternoon.

Are there any conditions or illnesses peculiar to seamen such as, in olden times, scurvy or rickets?

The most common thing, as far as an illness is concerned, is VD. Eye injuries are very common. Occasionally, I'll see people with malaria and typhoid and a lot with intestinal parasitic disease—if they stay long enough to diagnose. Seamen today seem to range in age from 16-70, and are generally healthy as patients go. Also, sanitary conditions on ships today are much better than they were 20 years ago, when they were **terrible**, especially on some developing nations' ships. Tuberculosis is

sometimes a problem with the ships of the developing nation, still, though.

Aboard Ship

If someone is killed on a ship while it's in port, are you the one called in?

No. The State Medical Examiner takes care of that but, most times—with a severe injury or a death—they'll call the city ambulance and the police. They **won't** call me.

How often do you have to board a vessel to treat a sick patient?

Fairly often, but mostly, I go down to give vaccinations. They're usually very well-organized with this and have been doing it for years. They have a list of the crew members and what shots they need. They have the books out and ready, and the whole thing can be done very easily. If it's **not** well-organized, it takes a long time, because you have to look through each person's book to identify the book with the person. This is difficult if they don't speak English. Proper examination of the sick and their treatment on board poses problems. Certain shots—like yellow fever—can't be given on the ships, because the vaccine must be frozen all the time and expires rapidly when thawed. For these, I have to use my office, which is also ideally-located in that it's central to all manner of specialists in this neighborhood: orthopedists, pharmacists, ophthalmologists, dentists, radiologists, eye-glass people, etc. The big problem for the sailors is transportation. If you have to transport them to the Greater Baltimore Medical Center in Towson or to Hopkins to see somebody, you get tied up in red tape in the hospitals. It's not only time-consuming, but you need an interpreter and a guide to take them around, too. Here, they can walk.

As for hospitalization, the Immigration authorities prefer for the sailors to go to the US Public Health Service Hospital in Wyman Park in Baltimore, so they know where they are most of the time. All the sailors are eligible for care there, and the insurance companies like for them to be there, too, because it's on a per diem basis and the costs are reasonably predictable.

Fee Payment

How are YOU paid—by check or currency?

I submit my bill to the owners of the vessels through the local agents, who send it to the insurance companies and back through the chain to me.

How long does the process take for one patient?

Sometimes up to a year and sometimes never, if the company disappears or goes bankrupt. I'm now collecting money, for example, on work I did a year ago. The Venezuelans pay right away, because they send money with the ships to disburse here.

The Ships' Complements

What's the average size of a crew of a tanker or freighter that comes into Baltimore?

It varies a great deal, but an average would be about 30-35. The smaller the ship, the smaller the crew, although this rule doesn't necessarily hold true with the larger ships, which are often fully-automated, with the

crew-size down in the twenties sometimes. On the other hand, on an Indian, Pakistani or other Third World ship, you may find as many as 60 persons!

Do all these ships have their own doctors aboard?

None of them do, unless they have more than 12 passengers or more than 100 in the crew. They can get medical advice in an emergency by radio if need be.

Have you had occasion to treat Soviet sailors?

They have a nurse practitioner or doctor on board who takes care of most things—such as VD—and they won't come to me unless it's quite serious. They usually arrive in the office with one or two others; never do they drift in here alone as some other sailors will do.

The Language Barrier

When you board the ships, do they have translators to help you?

Yes. As a rule, somebody speaks English. It's very hard to get interpreters for Finnish and Turkish, and some other languages, though. In these cases, we have three-way conversations on the phone quite often, with myself, the patient and another doctor who speaks the particular language all participating. The language problem produces many funny remarks. For instance, I've picked up some Greek terms here that I wouldn't use in the general course of conversation **in Greece!** The same goes for my Italian, a lot of which is slang that I've picked up from listening to translators. They're not very **scientific** expressions, I can tell you!

Examples of problems with languages results in some humorous incidents, such as the seaman who disrobed in the dentist's chair and indicated he wanted a circumcision, and the Italian engineer who said "Ia hava the trouble with the lova machinery—she cry;" the Indians who were told the toilet was "All the way out to the back," and later a pedestrian came in from the street and said that there were some men urinating in the back garden!

Difficulties with medications include eating suppositories and inserting them with the paper on. There're also difficulties with the administration of medicine and the need to be very sure of their understanding of the dose and frequency. This is helped by some pharmacists who deal with the ship who're multilingual. Recently, a passenger who spoke no English was put on a plane with a urethral catheter to which was attached a bag to collect the urine. The stewardess took the bag and tried to put it in the baggage locker with predictable results, pulling the patient with it.

Boarding the ship can be somewhat hair-raising at times, especially in the winter from a bobbing launch at sea. Jumping onto an ice-covered gangway or a rope Jacob's ladder can be tricky, also. Some gangways are very steep, so occasionally, it's necessary to use a crane and bucket, or to board a vessel in the stream from a helicopter.

A Physician's Desire

It sounds as if you enjoy your work.

Oh, I do! It's a lot of fun if you like to learn about

different people's customs, geography and history, such as the famous Ashanti nation of Africa, the life and habits of Somalis, Chinese ideas of medical treatment, etc.

If you could do or have one thing to improve your practice, what would it be?

Predictability of when the patients will arrive!

Thank you, Dr. MacGibbon.

Acknowledgments

The author thanks Med-Chi Communications Director Ms. Elza Davis for first suggesting this story to him in—alas!—1976, and Mrs. Mildred Chronister for secretarial services. □

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Accredited Cancer Programs in Maryland

By JOSEPH M. MILLER, MD

Dr. Miller is Chairman for Maryland of the Field Liaison Program, Commission on Cancer, American College of Surgeons, and is also Director of Medical Education at Provident Hospital, Inc., Balto., MD 21215, where he can be contacted for reprint and other data.

Cancer is the second greatest cause of death in the United States. About 650,000 new cases occur in the US every year, and approximately half of this number die of cancer.

Treatment of cancer is much varied in efficacy. Results of initial treatment and frequency of persistency of lesions are generally unpredictable. In the thrust to improve results from specified treatment: 1) Patients with cancer should have the advantages of a multidisciplinary approach during all stages of therapy, 2) cancer conferences should be held in each hospital for continuing education of all physicians, 3) the hospital should have a functioning cancer registry which is an autonomous unit of the hospital, directly accountable to the hospital administration and professionally supervised by the cancer committee.

The total care of the cancer patient entails more than the initial treatment. Rehabilitative measures, persistence of the lesion with overt reappearance in later years and occurrence of primary cancer in other sites, perhaps related to the primary treatment, make registration of these patients in an organized system for long-term surveillance mandatory.

Such a system will lead to improved patient care and contribute to a valid record of end-results for evaluation of treatment. A properly-organized cancer registry in continuous operation will fulfill these requirements.

Maryland now has 11 hospitals among its 50 which have approved cancer programs. Every hospital in the state which has facilities for cancer therapy should have such a program. The qualifications are:

1. The hospital must be accredited by the Joint Commission on the Accreditation of Hospitals.
2. A multidisciplinary Cancer Committee must function in the hospital and must be responsible for:
 - a. A Cancer Registry
 - b. Educational cancer conferences
 - c. Consultation services
 - d. A system of quality-care evaluation with documentation of its operation.

The responsibilities of the cancer committee cover the entire spectrum of cancer care. Membership, therefore, must include representation from surgery, internal medicine, chemotherapy, radiology and pathology.

Follow-up care is most important. To maintain an accredited status, the hospital must insure that at least 90% of its patients are cared for in this way.

The entire effort looks to quality care and quality survival. Patient evaluation in an environment of a multidisciplinary approach is continuously stressed.

The vital link which holds the cancer program in any hospital together is the Liaison Fellow or Associate. Truly a labor of love without financial recompense, this person

1. Will make monthly or perhaps more frequent visits to the cancer registry to discuss problems and seek improvement.
2. Will supervise the clinical tumor program to make the monthly cancer conferences rewarding. Educational films should be shown to the house and hospital staffs.
3. Will meet with the Program Surveyor at the time of review.

Only a small minority of the hospitals in Maryland which treat cancer have an approved program. Of 16,003 beds in the state which might be used to treat cancer, only 4,925 (31%) are in hospitals with an approved program. The good which might arise from a 100% participation can only be envisaged. The fact that a patient has been registered in a hospital program means that a lifetime of follow-up is assured. If the primary physician changes location, retires or dies, continuity of care is forthcoming. A secondary function of the registry is the distribution of accumulated data which reveals the results of efforts by the hospital as a whole which may be compared to regional or national statistics.

Every hospital seeing cancer patients can afford to have a cancer registry. Perhaps the statement should be rewritten that every hospital seeing such patients can not afford not to have a registry.

Hospitals in Maryland which are now accredited include:

1. Franklin Square Hospital, Baltimore
2. Greater Baltimore Medical Center
3. Johns Hopkins Hospital, Baltimore
4. Sinai Hospital of Baltimore
5. Saint Joseph Hospital, Baltimore
6. US Public Health Service Hospital, Baltimore
7. University of Maryland Hospital, Baltimore
8. National Naval Medical Center, Bethesda
9. Saint Mary's Hospital, Leonardtown
10. Peninsula General Hospital, Salisbury
11. South Baltimore General Hospital.

Surgical Treatment of Recurrent Pelvic Cancer After Irradiation

By UMBERTO VILLASANTA, MD, FACOG

Dr. Villasanta's paper is from the Department of Obstetrics and Gynecology at the University of Maryland School of Medicine in Baltimore, where he can be contacted for reprint and other data.

Introduction

Treatment of invasive carcinoma of the cervix (IC stage I-IV) by irradiation produces between 40 and 50% five-year survival. This means that over one-half of the patients treated will have persistent or recurrent disease within five years. Because cervical cancer prefers to spread by direct extension along tissue spaces or lymphatic channels, it remains confined within the cervix and immediately adjacent tissue for a relatively long time before producing distant metastases.¹⁻²

Early diagnosis and management of recurrent malignancy is a difficult problem. Retreatment of radiation failures by irradiation has been attempted. The results have been poor and the incidence of serious complications very high.³⁻⁴ The latter are becoming worse since the introduction of high energy sources, because of the large dose of irradiation delivered to the pelvic tissues surrounding the tumor, which approximates the limit of tolerance. Any further irradiation will result in necrosis and sluff with often lethal consequences.

Better results have been obtained with the use of surgery after radiation failure.⁵⁻⁸ The purpose of this presentation is to add documentation to this method of treatment.

Material and Methods

Several hundred patients who had primary treatment of their pelvic malignancy at this institution or elsewhere were found to have recurrence through the past 15 years. It is impossible to calculate how many patients were selected to be candidates for surgical treatment, because an underterminate number of them refused for different reasons to consent to the operative procedure. This report is based on 100 consecutive patients who accepted surgical treatment for cure of pelvic malignancy after failure of irradiation.

In most patients, tissue diagnosis of recurrence was obtained before surgery, in a few only X-ray evidence or clinical impression was considered valid indication for treatment.⁹ All patients had a previous carcinoma of the cervix with the exception of three who had carcinoma of the ovary (1) or endometrium. (2) Because several patients had their primary treatment at other hospitals and the clinical stage of the disease was unknown, no attempt has been made to analyze the extension of disease at the time of initial diagnosis.

Preoperative evaluation included: complete physical examination, cystoscopy, proctoscopy, long bones survey, chest X-ray, IVP, small bowel series, Barium enema, lymphangiography, liver scan, retrograde pyelogram, pelvic arteriography; however, not all these tests were performed in all patients and the presence of a non-functioning kidney or hydronephrosis was not considered a contraindication for surgery.

Of the 100 patients explored, 42 received less than curative surgery because of extension of recurrent tumor: the procedure ranged between exploratory laparotomy, biopsy and frozen section, to various type of intestinal or urinary tract bypasses. All these patients died of their malignancy and will not be evaluated further.

In the remaining 58 cases, the type and extension of operation was decided after exploration and tailored to the extension of the recurrent disease.⁵ The average age at the time of first treatment (by irradiation) of these 58 patients was 42.6 years, while at the time of surgery for recurrence it was 46.8 years. The mean interval was therefore 51 months. In 15 patients (26%), the recurrence was diagnosed five years or longer after primary treatment and in eight patients more than 10 years after irradi-

ation. The following procedures were done: 11 simple hysterectomies, 11 radical hysterectomies, 31 exenterations (22 total, eight anterior and one posterior), a inguinal lymph node dissection, three segmental resection of the sigmoid colon and a pulmonary lobectomy.

Results

Of 58 patients operated upon with the intent of encompassing the tumor and the aim of cure, 24 (41.4%) are alive and well over five years later (Table 1). The operative mortality was

TABLE 1: Results of Surgical Treatment After Irradiation Failure

	Total	Operative Mortality		Survival	
		#	%	#	%
Abdominal Hysterectomy	11	—		9	82%
Radical Hysterectomy	11	2	18%	4(5)*	36%(45%)
Exenteration	31	11	35.5%	8(9)**	26%(29)%
Miscellaneous	5	—		3	60%
Total	58	13	22.4%	24(26)	41.4% (44.8%)

* Corrected for one death due to coronary thrombosis 18 months after surgery

** Corrected for one death due to malignant lymphoma 56 months after surgery

22.4%; it was much higher after exenterative procedure (Table 2) and nil after simple hysterectomy or miscellaneous surgery. Two patients died, of sepsis and uremia, among the 11 subjected to radical hysterectomy and pelvic lymph node dissection. This appears high, but the total number of patients considered is small. Among the patients with miscellaneous procedures, three (two after segmental resection of the sigmoid colon and one after pulmonary lobectomy), are alive and free of disease over five years later.

Sepsis was the cause of death in seven patients, uremia in two, pulmonary embolism in two, and in the remainder multiple factors were involved. Thirteen patients (22%) required additional surgery to correct various complications such as: small bowel obstruction, vesico-vaginal, rectovaginal or uretero-vaginal fistulas, hydronephrosis, prolapse of colostomy, etc. Eight of these patients died subsequently of carcinoma, while five are alive and free of disease.

One patient died of coronary thrombosis, 18 months after radical hysterectomy and was found free of tumor at autopsy. Another patient died of a malignant mesenteric lymphoma 56 months after anterior exenteration.

Nineteen patients (32.7%) died of cancer on the average 23.7 months after surgery with extremes of two and 104 months. They all had pelvic recurrence and quite a few distant metastases.

The pelvic lymph nodes were available for examination in 42 patients (Table 3). Of the eight patients with positive lymph nodes, four died of cancer and two of complications. One with obturator metastases is alive and free of disease over five years after radical hysterectomy and another, subjected to the same operation after a "false negative" frozen section of a periaortic node that was proven metastatic after permanent section, is also alive 72 months later. Of 34 patients with negative lymph nodes, 11 (32%) died of cancer, 13 (38%) of complications and 10 (30%) are alive.

TABLE 2: Results of Exenterative Operations

	Total	Alive	Died of Complications	Died of Intercurrent Disease	Died of Cancer
Total Exenteration	22	6	9	—	7
Ant. Exenteration	8	2	1	1	4
Post. Exenteration	1	—	1	—	—
Total	31	8(25.8%)	11(35.5%)	1(3.2%)	11(35.5%)

TABLE 3: Status of Lymph Nodes and Survival

Lymph Nodes	Total	Survivors	Dead of Complications	Dead of Cancer
Positive	8	2	2	4
Negative	34*	10	11	11

* 2 patients with negative nodes died of intercurrent disease

Contrary to the findings of Halpin et al, 10 patients who had recurrence shortly after irradiation had poor survival, while those who recurred later had the best survival (Table 4). This certainly reflects the high virulence of the malignant tumor and the poor host resistance as previously observed (11.)

TABLE 4:

Interval Between Primary Treatment and Recurrence	Interval	Number	Survival
< 12 months		21	3
13-24 months		11	5
25-36 months		3	1
37-48 months		4	3
48-60 months		4	2
> 61 months		15	10
Total		58	24

Comment

The great majority of cervical carcinoma in the United States are treated by irradiation. About one-half of these patients will have recurrent or persistent disease (as defined by finding of the cancer in the primary site within six months). Reirradiation of these recurrent tumors is not satisfactory because of the low percentage of "cures" and the high incidence of serious and debilitating complications.

Th surgical approach for irradiation failures offers much better results. The operability rate of patients included in this study (58%) reveals a very good preoperative selection. It is possible that inclusion of more patients could have increased the "cure" rate, in as much as all patients not operated upon died of cancer.

All patients should be prepared for the most radical operation, and the extent of the procedure should be tailored to the extent of the disease and the need of the patient. One should attempt to remove the tumor "en block" with a good margin of normal tissue around it.

The surgical mortality of 22.4% is acceptable, considering that without operation the mortality would be 100%. The over-all five years survival of 41.4% for this group of patients appears excellent. Even a single metastasis in large bowel or lung should be considered for surgical removal because on occasion it will result in a long survival.

The complications rate is proportional to the extension of the surgical dissection. Most of the surgical deaths were due to sepsy. All patients who died of cancer had pelvic recurrence and, in some cases, distant metastases. The incidence of secondary opera-

tion for post-surgical complications appears also acceptable.

The presence of metastatic cancer in the pelvic lymph nodes aggravates the prognosis, but does not preclude survival. On the other side, the finding of negative lymph nodes is no guarantee of cure.

There seems to be a direct relationship between the virulence of the tumor, the rapidity of recurrence and the mortality after re-treatment.

Even the most radical operation succeeded in a satisfactory cure rate (25.8%), in spite of the high postoperative mortality (35.5%) observed in this group of patients.

Most patients with recurrent pelvic carcinoma are regarded as hopeless cases. It would be about time that physicians would start to recognize that something can be gained by an aggressive surgical treatment. Even if the postoperative mortality and the serious complications are high, a 45% survival is certainly better than the inevitable suffering and death due to untreated recurrent malignancy.

Summary

One hundred patients with recurrent pelvic malignancy following irradiation therapy were considered for surgical treatment. Of these, 42 were found to have nonresectable tumors and noncurative treatment was carried out. In the remaining 58, an operation was performed with the intent to eradicate the malignancy. All patients had originally an invasive carcinoma of the cervix, with the exception of three who had carcinoma of the ovary and endometrium. All patients had preoperative evaluation consisting of chest X-ray, long bone series, IVP, Ba enema, lymphangiography, liver scan, etc. The extent of the surgical procedure was determined by the finding at the time of laparotomy. It ranged from simple hysterectomy, to radical hysterectomy, exenteration (22 total, eight anterior, one posterior) and other procedures; 32.7% of the patients operated with the intent of cure died of malignancy, on the average 24 months after surgery; 22.4% of patients died of complications arising from surgery. One patient died of coronary thrombosis and another of lymphoma 18 and 56 months respectively after surgery. The remaining 41.4% are alive and free of tumor over five years after surgical treatment. While reirradiation of patients with post-radiation recurrent malignancy has shown to result in poor survival and excessive serious complications, surgical treatment will succeed in curing a considerable percentage of patients.

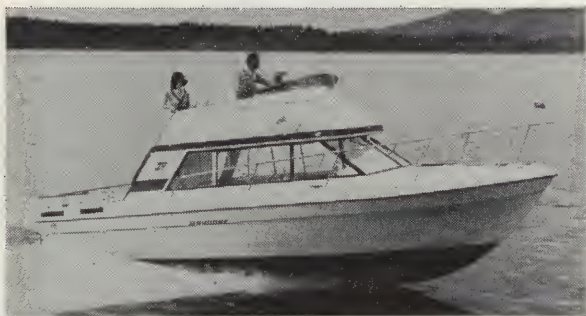
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DOCTORS IN THE NEWS: Dr. Robert L. Hirschfeld of Timonium will be named a Fellow of the American College of Radiology at its Annual Meeting in Chicago Sept. 19th. Dr. Hirschfeld, a 1959 graduate of the Duke University School of Medicine, is affiliated with the Greater Baltimore Medical Center, Sheppard Pratt Hospital in Towson and the US Public Health Service Hospital in Baltimore.

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**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl[®]

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects[†]

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS. Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS.** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS.** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Doctors in the News

Dr. Conn Honored

The Board of Trustees of the Society for Clinical and Experimental Hypnosis has designated Dr. Jacob H. Conn to be the first Perpetual Fellow of the Society.

Dr. Conn is an Assistant Professor Emeritus of the Johns Hopkins University Medical School and is on the active staff of the Johns Hopkins Hospital. He was the recipient of the first Milton H. Erickson Award of the American Society for Clinical Hypnosis for Scientific Excellence for Writing in Hypnosis in 1971.

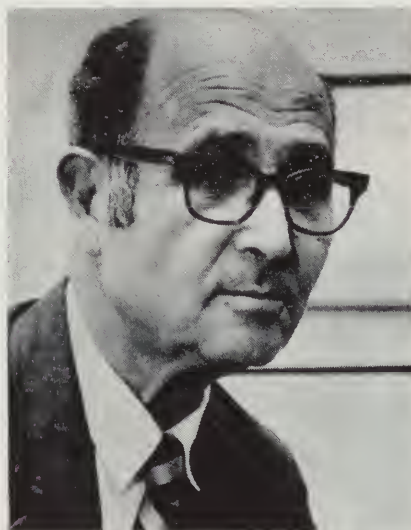
Dr. Conn is the recipient of every award in medical hypnosis presented by the Society for Clinical and Experimental Hypnosis. He received the Awards for the best paper in Scientific and Clinical Hypnosis in 1960 and 1968, the 1961 Raginsky Award for Leadership and Achievement as a "Distinguished Psychiatrist, Teacher, Scientist and Pioneer in Hypnotherapy" and the 1964 Schneck Award "to the Physician who made Significant Contributions to Scientific Hypnosis." Dr. Conn also is the recipient of the 1965 S. C. E. H. Presidential Award for his "outstanding work in the field of hypnosis over a period of 25 years" and the first Gold Medal Award in 1970 for "Scientific Achievement for his Outstanding Professional Contri-

butions in the Field of Scientific Hypnosis."

Dr. Conn is an Associate Editor of The International Jr. S. C. E. H., a Scientific Consultant to the Mor-ton Prince Center for Hypnotherapy and an Honorary Member of the American Society of Psychosomatic Dentistry and Medicine.

He is a Past President of the Society for Clinical and Experimental Hypnosis and of the American Boards of Medical Hypnosis. He is the author of 110 scientific papers, past president of the Maryland Association of Private Practicing Psychiatrists and a Life Fellow of the American Psychiatric Association. He was the first practicing psychiatrist in Maryland to be certified by the American Boards of Psychiatry and Neurology (1935), Child Psychiatry (1939) and Medical Hypnosis (1959). Dr. Conn has been in the private practice of Psychiatry since 1933, and was the Acting Chief Medical Officer to the Supreme Bench of Baltimore, Consultant to the Federal Courts and to the Veteran's Administration. Dr. Conn is a 40-year member of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland and the American Medical Association.

On May 30, 1979, the Alumni Association of the University of Maryland School of Medicine presented Dr. Conn, as a member of the Class of 1929, with a Certificate for 50 Years of Service to the Community.



DR. CONN

Consultation Schedule:

Moderator: John Stupak
Alternate Wednesdays,
6:30-8 PM

Sept. 5th:

Raymond J. Donovan, MD
and Sr. Catherine Grace:
"Hospice"

Sept. 19th:

Maxwell Weisman, MD:
"Alcoholism"

Oct. 3rd:

William Dunseath, MD:
"Skin Problems"

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Heart Attack! The Number One Killer of US Adults

by Raymond D. Bahr, MD, FACP

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- * Community Apathy in Regard to Sudden Death Due to Heart Attack . . . p. 74**
- * A Message to John Q. Public . . . p. 76**
- * Early Warning Signs . . . p. 76**
- * CPR . . . p. 76**
- * Maryland's Emergency Medical Telephone Numbers . . . p. 77**
- * Hospitals in Maryland . . . p. 80**
- * How One Baltimore Hospital—St. Agnes—is Handling the Problem: The Chest Pain Emergency Room . . . p. 82**

-:- -:- -:-

From the American Heart Association Central Maryland Chapter:

- * Hospital Emergency Rooms Should Meet Quality Standards . . . p. 83**
- * Stop Heart Attack Deaths Campaign Put Into Action . . . p. 84**

The following material is meant for both physicians—who should be familiar with all of it— and laypersons, the physicians' patients. The section is perforated for easy tear-out out for patient use or reproduction. This section represents the **Journal's** contribution to the issue so cogently raised by Dr. Bahr in his **Open Forum** letter on page 8 in this edition.—BT.

Community Apathy in Regard to Sudden Death Due to Heart Attack

By RAYMOND D. BAHR, MD, FACP

Dr. Bahr is Director of the Coronary Care System at St. Agnes Hospital, 900 Caton Ave., Balto., MD 21229, where he can be contacted for reprint and other data.

Much information about the cause of heart attacks is missing from the medical literature; however, information about the cause of sudden death from heart attacks is *not* missing. Perhaps even more important is the fact that in the majority of cases, it is a completely reversible event. Why then, do two-thirds of the deaths take place outside the hospital? This is unbelievably shocking. Certain factors are known to exist that perpetuate this #1 killer of the adult population of the United States. Community apathy is present at this important link in emergency cardiac care.

It is well-known that cardiopulmonary resuscitation can save lives. To this extent, efforts have been made

in Maryland to teach as many people as possible the simple techniques of this lifesaving procedure. The Baltimore Sun, The Fire Departments, the Heart Association, etc., are to be congratulated for the push in this direction. It is still considered rather feeble when compared to the city of Seattle, Washington, where 70% of the population are trained in CPR techniques. Probably the most important place to start is at the high school level and, to this extent, certain high schools in Maryland are requiring CPR as part of their curriculum and it thus becomes part of the basic four Rs (reading, riting, 'rithmetic and resuscitation.)

True CPR saves lives, but isn't it better to save a life by bringing them into the hospital early enough to prevent the need for resuscitation? It is well-known that cardiac arrest is time-related and most of the events take place shortly after that attack. It is at this

HEART ATTACK GUIDE

1. Know the Early Warning Signs



2. Call the Ambulance



3. Go to the Hospital




crucial point that community apathy exists. The apathy is derived from two elements; one is lack of knowledge about the early warning signs of a heart attack and, two, the naturally-occurring defensive mechanisms of denial and procrastination that exists in each one of us when confronted with a possible anxious situation such as a heart attack. A combination of these two continues to drive up the high mortality rate in the U S today. How, then, to overcome these two elements? Every home should have a person not only knowledgeable in CPR, but also cognizant of the early warning signs so that there exists an "Executive Spouse." The key here is the "Executive Spouse" and is defined as a person within the family who does not put up with the excuses from a patient having suffered chest pain but immediately calls into play the Emergency Cardiac Care System (911 in some communities and the Fire Department in other communities). Valuable time will be saved and the result will be the salvage of many persons with hearts too good to die.

There exists an excellent Emergency Cardiac Care System in Maryland. Qualified cardiac ambulance attendants stabilize the patient upon the scene. Voice communication as well as EKG transmission is accomplished almost immediately and the nearby hospital is

kept abreast of the situation by a console provided in the Emergency Room.

It would seem that to enhance recognition of the early warning signs and the rapid entry into the Emergency Cardiac Care System with the help of an "Executive Spouse" in each household would go a long way in driving down the high mortality figures from sudden death in our community. To this extent, the community must become enlightened to overcome this apathy relating to the heart attack problem. □



STOP

HEART ATTACK DEATHS

Know the Signals of HEART ATTACK


SIGNALS

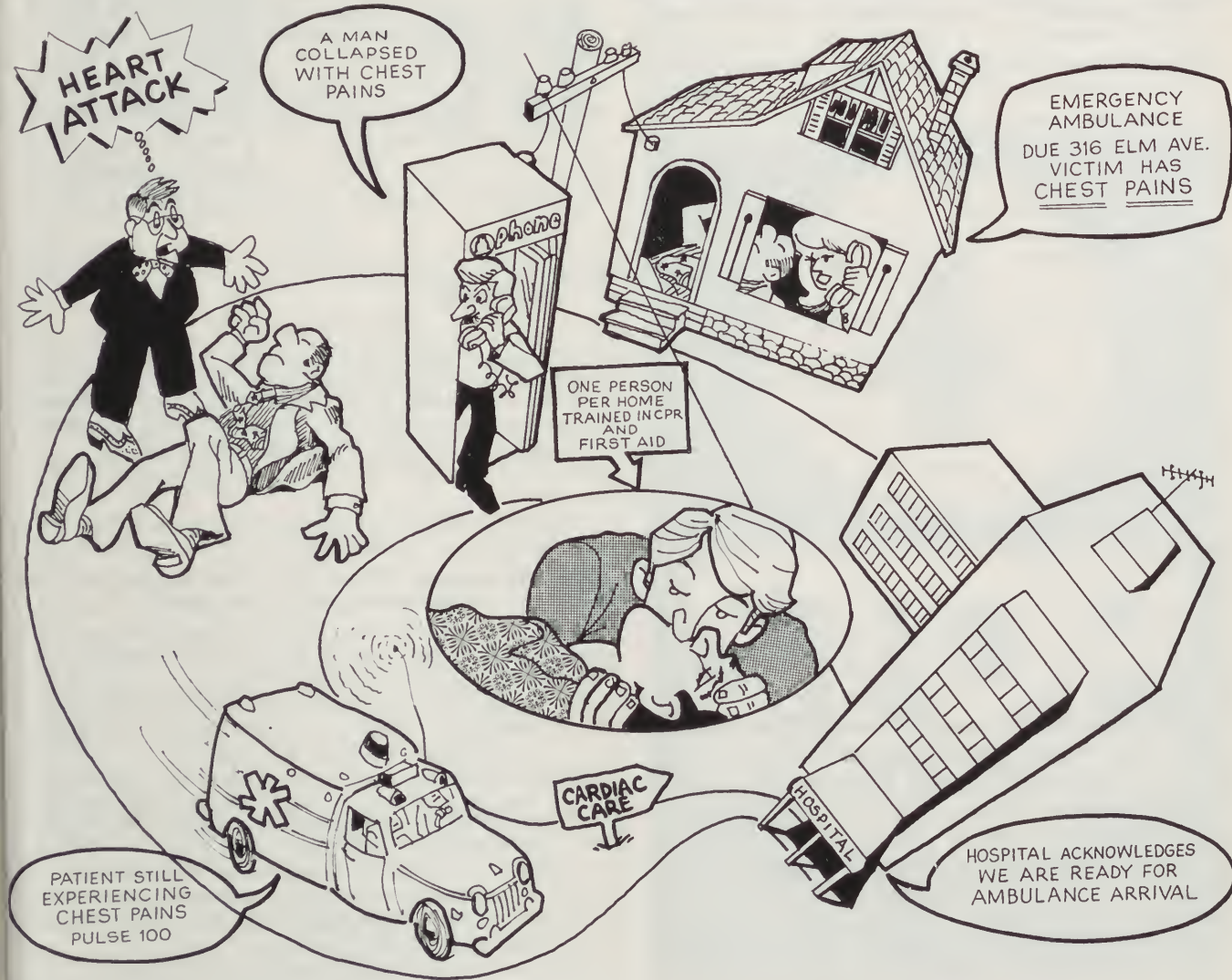
1. An uncomfortable pressure, squeezing, fullness or pain in the center of the chest lasting 2 minutes or more.
2. Dizziness, fainting, sweating, nausea or shortness of breath may also occur.

ACTION

1. Call 396-1111 (Baltimore City Ambulance)
2. Get to the nearest hospital emergency room (Do not drive yourself)

AMERICAN HEART ASSOCIATION
CENTRAL MARYLAND CHAPTER





Heart Attack!

A Message to John Q. Public

By RAYMOND D. BAHR, MD, FACP

Dr. Bahr is Director of the Coronary Care System at St. Agnes Hospital, 900 Caton Ave., Balto., MD 21229, where he can be contacted for reprint and other data.

Update your knowledge about this potential killer in your household.

Learn what is available in the community.

More important, learn what *you* can do to prevent sudden death in a heart attack victim.

Learn the simple techniques needed to resuscitate a "dead" victim.

Learn how to stay heart-healthy and avoid all of this for you and your family.

Is there any of this that is important to you?

It has been reported that two-thirds of the heart attack victims die before they reach the Hospital. Most people *underestimate* the aspects of sudden death associated with a heart attack. Many of these deaths are *completely avoidable*, since the cause of death is a temporary electrical problem in an otherwise properly-functioning heart. It then becomes very important to know *what to do*. Learn the *Early Warning Signs* of an impending Heart Attack.

The patient usually has chest pain and/or pressure-with discomfort in the middle of the chest. The pain comes on slowly and builds up. It usually cannot be localized and it is often described as diffuse, or "spread out." In many cases the patient will clench his/her fist over the center of the chest.

The pain may radiate to the left arm (inner aspect) or to the jaw.

Often the patient experiences nausea, vomiting, cold sweating and may even pass out.

Unfortunately, the patient does not communicate this discomfort and often will deny the problem. The patient may distinguish the discomfort from pain by saying "it is a pressure," "heavy feeling," "constricting sensation" etc.

In many cases it is passed off as indigestion. Many a dead victim has been found alone, in his home or outside, clenching Tums in his hand. Knowledge of the important *Early Warning Signs* by family members will go a long way to prevent sudden death.

Should the victim stop breathing or lose his pulse, knowledge and application of the simple techniques of resuscitation (namely, establish airway, provide breathing, begin artificial circulation) is a must in order to sustain the victim until help arrives.

When any of the above take place, Help is summoned by calling for an ambulance (in some areas of our state the emergency number 911 is available to contact such emergency vehicles, if this number is not

CARDIOPULMONARY RESUSCITATION IN BASIC LIFE SUPPORT

Place Victim Flat On His Back On A Hard Surface

IF UNCONSCIOUS, OPEN AIRWAY

LIFT UP NECK
PUSH FOREHEAD BACK
CLEAR OUT MOUTH IF NECESSARY
OBSERVE FOR BREATHING



IF NOT BREATHING, BEGIN ARTIFICIAL BREATHING

4 QUICK FULL BREATHS

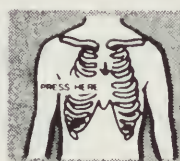


CHECK CAROTID PULSE

IF PULSE ABSENT, BEGIN ARTIFICIAL CIRCULATION



DEPRESS STERNUM 1½" TO 2"



ONE RESCUER
15 compressions
rate 80 per min.
2 quick breaths

TWO RESCUERS
5 compressions
rate 60 per min.
1 breath



CONTINUE UNINTERRUPTED UNTIL ADVANCED LIFE SUPPORT IS AVAILABLE

CPR

Heart Attack!

Early Warning Signs

The patient usually has chest pain or pressure in the middle of his chest. The pain comes on slowly and builds up. It usually cannot be localized and it is often described as diffuse, or "spread out." In many cases, the patient will clench his fist over the center of his chest.

The pain may radiate to the left arm (inner aspect) or to the jaw.

Often the patient experiences nausea, vomiting, cold sweating and may even pass out.

Steps Necessary to Prevent Death From the Number One Adult Killer in the US: Heart Attack!

Learn the Early Warning Signs. Prevent the need for resuscitation by bringing the patient to the hospital at an earlier stage. Overcome denial factors.

Be educated in Cardiopulmonary Resuscitation Techniques.

- Emergency Cardiac Vehicles staffed by certified cardiopulmonary rescue technicians.
- Cardiac consultation via control center at Sinal Hospital of Baltimore to one of four consult hospitals. (Stabilization takes place at the scene of the trouble. It is here that delay may take place in order to bring about stabilization prior to transport).
- Emergency Rooms giving priority to chest pain patient (St. Agnes Chest Pain Emergency Services now being completed).
- Coronary Care System within the hospital setting.

available in your location contact your Local Fire Department for an ambulance). Fortunately, in Maryland, most of the ambulances are staffed with certified cardiopulmonary rescue technicians proficient in emergency cardiac care. The patient's EKG pattern can be transmitted from the ambulance to any one of four cardiac consult centers via the control center located in Sinai Hospital in Baltimore. Once cardiac consultation is obtained and the patient stabilized, the ambulance proceeds to the hospital. The receiving hospital is made aware of the victim's imminent arrival. Maryland is very fortunate in having an excellent Emergency Medical system that provides the necessary link between the patient and the hospital. Great strides have been made in the last several years under the leadership of John Stafford, MD.

One other major ingredient in emergency cardiac care is the hospital Emergency Room. It is here that top priority is given to the cardiac patient, in terms of resuscitation as well as in terms of prevention of the problem. No longer is the chest pain victim routinely passed over in favor of patients needing surgical care. Most hospital emergency rooms in Maryland have updated their efforts, giving the cardiac patient top priority.

At St. Agnes Hospital in Baltimore, a specialized area (Chest Pain Emergency Services) has been built for treatment of Emergency Cardiac Patients. Personnel trained in Advanced Life Support staff this area. Admitted patients are transported via a special elevator to the Coronary Care Unit. This approach will prevent cardiac patients from being bottlenecked in the emergency room with patients having a variety of other medical emergency problems.

Let's now review the steps necessary to prevent death from the number one adult killer in the US: Heart Attack!

As private citizens and potential victims:

- * Learn the Early Warning Signs. Prevent the need for resuscitation by bringing the patient to the hospital at an earlier stage.
- * Educate yourself in Cardiopulmonary Resuscitation (CPR) Techniques.
- * Emergency Cardiac vehicles staffed by certified cardiopulmonary rescue technicians.
- * Cardiac consultation via control center at Sinai Hospital of Baltimore to one of four consult hospitals. (Stabilization takes place at the scene of the trouble. It is here that delay may take place in order to bring about stabilization prior to transport).
- * Emergency Rooms giving priority to chest pain patients.
- * Coronary Care System within the hospital setting.

The public needs to be aware that Coronary Artery Disease may be prevented or slowed down by correcting the major risk factors associated with this disease, namely: hypertension, cigarette smoking and high levels of serum blood cholesterol. It has been shown that regular physical exercise is beneficial in helping to prevent Coronary Artery Disease and also in recon-

ditioning the Coronary Artery Disease victim. To this end, Catonsville Community College in Baltimore County, for example, has established a supervised exercise program.

John Q. Public, Learn to do your part in Heart Disease Prevention and treatment. Health is the Greatest Gift in Life. You may bring about a Happy (Heart) Ending. □

Heart Attack!

Maryland's Emergency Medical Telephone Numbers

Allegany County 777-7111 (8/79-911)	Cecil County 911	Prince George's County 911
Anne Arundel County 987-1212	Charles County 911	Queen Anne's County 758-0222
Baltimore City 396-1111	Dorchester County 228-2222	St. Mary's County 911
Baltimore County 823-2020 (8/79-911)	Frederick County 662-6333	Somerset County 651-2333
Caroline County 479-2222	Garrett County 911	Talbot County 822-2222
Calvert County 911	Harford County 828-3333	Washington County 791-1211
Carroll County 848-4343	Howard County 911	Wicomico County 749-4141
	Kent County 911	Worcester County 632-1313
	Montgomery County 911	



STOP HEART ATTACK DEATHS

Know the Signals of HEART ATTACK

Heart Attack!



Need for an Executive Spouse
Knowledge of CPR Techniques
PLUS

- Early Warning Signs
- Overcome Denial
- Rapid Entry into System (911)



OR



ARREST

2/3 Die Before
Reaching Hospital
(600,000 Deaths in the
USA each year)

Apathy exists here
(Weakest link in chain.)



COMMUNITY
Effort & Assignment
Responsibility
(Weak)



AMBULANCE
Cardiac attendants (CARTS)
stabilize on the spot
by contacting the
CONTROL CENTER

VOICE
and EKG
Transmission

- Cardiac Consultation
from CENTER

Passive
Transmission
to St. Agnes

Central
Center
(SINAI)

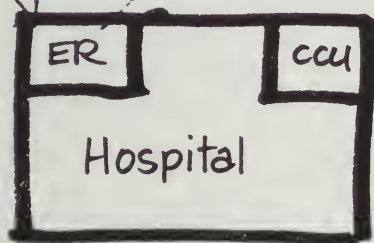
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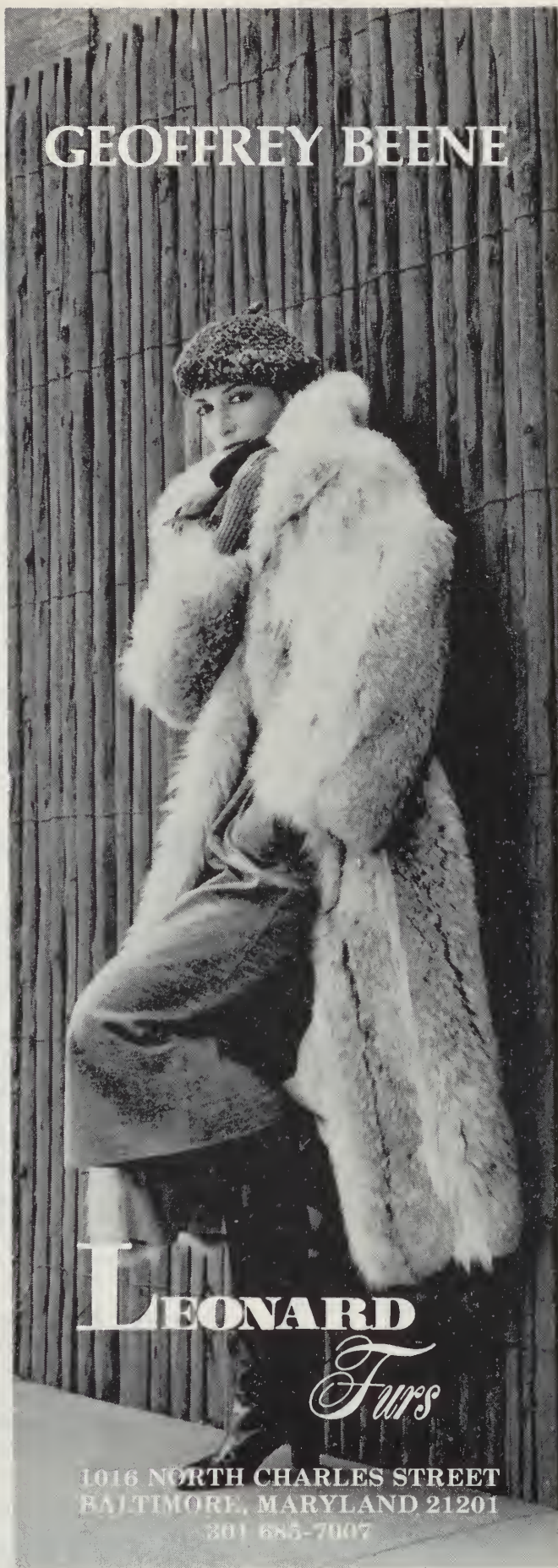
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The Chest Pain Emergency Room

By RAYMOND D. BAHR, MD, FACP

Dr. Bahr's Director of the Coronary Care System at St. Agnes Hospital, 900 Caton Ave., Balto., MD 21229, where he can be contacted for reprint and other data.

Where is the Chest Pain Emergency Room? What is its purpose? How will it function? How will it bridge the gap between St. Agnes Hospital and the St. Agnes community?

These are all questions being raised concerning the structure now being built on the north side of the building facing Wilkens Ave. It connects directly with the Emergency Room and thus forms *part* of the Emergency Room, an extension, you might call it, which gives priority care to a highly-selective Emergency Room problem which deals with sudden death. On the south side of this, there is a two-story structure which connects with the second floor. This connection is via an elevator which will provide rapid entrance from the Chest Pain Emergency Room to the Coronary Care System on the second floor. What prompted St. Agnes Hospital to undertake such an innovative approach to the problem of Coronary Care? It has been long recognized that the major problem with coronary artery disease lies *with the community* and *not* with the hospital. This is not to say that lives are not saved within the hospital, but gives due importance to the weight of the problem's being in the community.

It is estimated that two-thirds of the patients who die with coronary artery disease do so before reaching the hospital. Approximately 50% die instantaneously within one minute; another 20% within the first two hours, with frequency falling off after the first six-eight hours. Unfortunately, most studies show that the approximate time of arrival to the Emergency Room of patients suffering a heart attack is about six hours, thus the major killing force has already struck its blow and wiped off the face of the earth many a patient with a heart too good to die.

In order to correct such a problem, the Hospital must extend itself into the community and *educate the populace* in: 1) What to do when the patient is having a cardiac arrest and 2) Concepts of coronary care that preach the importance of seeking early medical attention shortly after the insult has taken place. The solution to the first of these problems has been shown by the people of Seattle to be very effective: 70% of the Seattle population know how to do cardiopulmonary resuscitation. No longer are these simple techniques relegated to the physician or his/her designated personnel, but must be given through qualified courses certifying as many lay people as possible. A solution to the second of these problems is perhaps more difficult to come up with. True, we do preach that all patients with chest pain seek emergency medical help, but as

one knows, it can be very frustrating and catastrophic when the Emergency Room is full and there is "no place in the lin." With this in mind, the concept of a Chest Pain Emergency Room was designed to incorporate the following principles:

1. A large resuscitation area
2. An observation area for patients with chest pain
3. A rehabilitation area
4. A cardiac consult area where nurses can keep in contact with incoming ambulance calls as well as EKG rhythms
5. A dedicated elevator that expedites patients immediately to the Coronary Intensive Care Area (Phase F.)

In a busy hospital such as St. Agnes, in order to have a rapid entry of patients early in the course of their illness, it is important to also have a rapid discharge capability that will keep up with the rapid entry. We hope to do this by cutting down on the length of stay on certain subsets of good risk patients as well as providing rapid rehabilitation for uncomplicated MIs so as to allow patients in the early course of their illness to be admitted.

There is no question that we will have a greater impact on sudden death in the community if we are able to reach patients at an earlier stage of their illness. The Chest Pain Emergency Room will also allow for proper identification of the true MI suspects rather than subject the patient to a cutoff time of 12 hours. The latter at times has caused dilution of non-MIs in the Unit as well as having sent home patients with unstable anginal pictures.

The hallmark of this area will be a team of Chest Pain Emergency Room Nurses who will be dedicated to emergency care of the cardiac patient. Monitoring equipment will be available to allow rapid identification and treatment of life-threatening arrhythmias. It is better to save a life by preventing a resuscitation than by having a patient deteriorate to the point where resuscitation is inevitable.

The entire concept of the Chest Pain Emergency Room is an innovative one that will suffer some growing pains in its early stages. These growing pains will not be insurmountable when one considers the nature of the problem (sudden death and a heart that's too good to die), the easy reversibility by drug therapy early in the course of the illness and the expertise of the Emergency Room physicians, Chest Pain Emergency Room nurses, Coronary Care residents, Cardiologists, etc., as well as administrative personnel working together to iron out the fine wrinkles, knowing full well that they are providing optimum cardiac care to people in our community. □

Heart Attack!

From the American Heart Association—

Central Maryland Chapter:

Hospital Emergency Rooms Should Meet Quality Standards

Hospital emergency rooms in Central Maryland are now displaying new red, white and blue signs which stand for quality cardiac care, according to Hilary T. O'Herlihy, MD, Chairman of the Emergency Cardiac Care Advisory Committee of the American Heart Association, Central Maryland Chapter.

"Hospitals displaying these signs are using Heart Association standards for emergency cardiac care," said Dr. O'Herlihy. "In meeting these standards, a hospital is expressing a belief in priority treatment for suspected cardiac patients."

Participation in the program is entirely voluntary. The program is sponsored jointly by the American Heart Association, Central Maryland Chapter and the Maryland Institute for Emergency Medical Services (MIEMS).

Dr. O'Herlihy said, "Anyone who comes into one of these hospitals complaining of chest pains is immediately admitted to the emergency rooms, bypassing routine red tape such as insurance forms, etc. This is important because of the high incidence of sudden death early in acute cardiac events. Many of these people are actually undergoing a heart attack when they walk into the hospital."

According to Dr. O'Herlihy, "In part, the standards indicate that a hospital emergency room is open and staffed with qualified personnel 24 hours a day. These staff people are trained to handle emergency cardiac cases and have all the necessary equipment and drugs readily available."

Dr. John Stafford, MD, Director for MIEMS Systems Program and a member of the American Heart Association, Central Maryland Chapter Emergency Cardiac Care Advisory Committee, said "Paramedic telemetry ambulances operating in Central Maryland transported 6,000 suspected cardiac patients to these emergency rooms last year." All the emergency rooms visited used the red box system. "When someone suspects a heart attack, he should immediately call an ambulance. Specially-trained paramedics can respond to an ambulance call in minutes. Upon arriving at the scene, these paramedics can immediately begin transmitting important information—blood pressure, pulse, heart rhythm—to a receiving hospital."

Dr. Stafford added, "In the hospitals we visited, we found that the receiving personnel were ready for a patient's arrival."

He urged people to learn how it feels to have a heart attack. "The way a heart attack feels can vary. If someone feels an uncomfortable pressure, fullness, squeezing or pain in the center of the chest that may spread to the shoulders, neck or arms, and if it lasts

for two minutes or more, he could be having a heart attack. Severe pain, dizziness, fainting, sweating, nausea or shortness of breath may also occur. Sharp, stabbing twinges of pain are usually *not* signals of a heart attack."

Dr. Stafford warned, "Surviving a heart attack may depend on getting medical attention quickly. Call an ambulance immediately. (See Table 1). Too many people refuse to accept the possibility that they are having a heart attack. Many people say it's indigestion or tension. They worry about embarrassment. They often wait three hours or longer before getting help, but before those three hours are up, one out of three is dead."

Dr. O'Herlihy explained, "All hospital emergency rooms were voluntarily visited by medical teams representing the American Heart Association, Central Maryland Chapter Emergency Cardiac Care Advisory Committee. These hospitals met the standards."

The mission of the American Heart Association is to reduce and ultimately eliminate premature death and disability from cardiovascular diseases. Nearly 7,100 people in Central Maryland died last year from cardiovascular diseases; 2,300 of these deaths were from heart attack. Half of these people died before entering the emergency medical system.

Because of its mission and its concern for the management of a heart attack patient, the American Heart Association developed these standards for emergency cardiac care in advanced life support units including hospital emergency rooms.

For further information about the warning signals of a heart attack and the emergency medical system, call the Heart Association at 685-7074. ☐

DOCTORS TAKE NOTE:

Oct. 26-27, Practical Clin. Endocrinology, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956 at Univ. of MD Sch. of Med.

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Hearts Attack!

Stop Heart Attack Deaths Campaign Put Into Action

Remember:

If you feel an uncomfortable pressure, squeezing, fullness or pain in the center of the chest, lasting for two minutes or more, you could be having a heart attack. Dizziness, fainting, sweating, nausea and shortness of breath may also occur.

The key to surviving a heart attack is to act immediately. Survival often depends on how quickly heart attack symptoms are recognized and how fast medical assistance is summoned. Approximately 350,000 people die each year from heart attacks before ever reaching the hospital. Many of these deaths happen suddenly, although seldom without some previous warning. Symptoms are too often ignored by the victim.

You can improve your chances of surviving a heart attack by recognizing the early warning signals and seeking emergency medical help immediately.

The American Heart Association-Central Maryland Chapter has launched a campaign to educate the inner-city community to recognize the warning signals of a heart attack, and know the telephone number to call to activate the Emergency Medical Services System's Cardiac-Equipped Ambulances.

The program, *Stop Heart Attack Deaths*, began in February, 1979. According to Project Director B. Wayne Kong, Ph.D. of Baltimore's Provident Hospital, the project's over-all effectiveness will be measured in a survey study by the University of Maryland Hospital

under the direction of Aristicle Apostolides, DVM, Ph.D.

A baseline survey, prior to the campaign, revealed that 20.4% of the people interviewed could recognize the signals of a heart attack if they were experiencing them, while 53% thought they would recognize someone else's symptoms. All those questioned thought they knew the name of the hospital closest to them, but no one knew the number to call for emergency medical assistance. (See Tables 2 and 3.)

Chairing the Early Warning Signals Planning and Coordinating Committee in Baltimore is Mrs. Vashti McKenzie. Other committee members are: Rev. John Bryant, Bethel AME; Irving Conway, Center 28, Urban Services Agency; Rev. St. George Cross, Lewin United Methodist Church; David Fuellhart, WPOC Radio; Mrs. Jacki Hill, Coppin State University; William Hathaway, MIEMS; John Murphy, III and Mrs. Ida Peters, executives of the *Afro-American Newspapers*; Mr. Al Raison; Chuck Richards, Baltimore Contractors; Elijah B. Saunders, MD, FACC, of Provident Hospital; Mrs. Betsy Simon, Baltimore City Public Schools; Melvin Wachs, Urban Services Agency; Mrs. Elizabeth A. Ward, Assistant to Delegate Hattie Harrison; Corinda Waters, Ph.D and Joseph Woodfolk.

If anyone is interested in receiving a free wallet card or a stick-on decal (see illustrations) detailing the early warning signals and the appropriate action to follow, please write or call the Chapter Office (American Heart Association-Central Maryland Chapter, 415 N. Charles St., PO Box 17025, Balto., MD 21203, (301) 685-7074.)

Large quantities can be ordered for organizations or special interest groups. ☐

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UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

BODY CT

PROGRAM

NEURO CT

October 10, morning

Welcome—John M. Dennis, M.D., and Joseph Whitley, M.D.

Moderator: Nancy Whitley, M.D.

CT of the Larynx — Stephen Cisternino, M.D.

CT of the Pulmonary Nodule — Stanley Siegelman, M.D.

CT of the Mediastinum and Pleura — Charles Putman, M.D.

CT Scanning of the Pancreas — Ralph Alfidi, M.D.

CT Scanning of Kidneys and Adrenals — Stanley Siegelman, M.D.

Comparative Aspects of Ultrasound and CT of the Retroperitoneum — Conrade C. Jaffe, M.D.

October 10, afternoon

Moderator: Morgan Dunne, M.D.

CT of the Pelvis — Nancy Whitley, M.D.

CT in Musculoskeletal Neoplasms — Peter Mueller, M.D.

Sequential CT Scanning after IV Contrast — Ralph Alfidi, M.D.

Clinical Application of Multiplanar Reconstruction in CT of the Abdomen — Conrade C. Jaffe, M.D.

Interventional CT — Peter Mueller, M.D.

October 11, morning

Moderator: Stephen Cisternino, M.D.

Global Abdominal Anatomy by Ultrasound and Computed Tomography — Morgan Dunne, M.D.

Computed Tomography of Trauma — Edward Druy, M.D.

New Developments in CT Technology — John Perry

The Use of CT in Radiation Therapy Planning — Ralph Scott, M.D.

October 11, midday: Workshop sessions at the University of Maryland Hospital and Johns Hopkins Hospital will demonstrate CT diagnostic activities in clinical settings.

Location: INTERNATIONAL HOTEL, Baltimore-Washington International Airport.

Pre-registration: Early pre-registration by mail is encouraged since conference facilities necessitate limited enrollment. Registration, with a \$15 late fee, will be possible on a space available basis at the International Hotel, 7:30 am, October 10 and 10:00 am, October 11.

Fee:

	Physicians	Residents, Interns and Other Professionals
Full 3-day course:	\$200	\$135
Body CT session only:	\$125	\$ 80
Neuro CT session only:	\$125	\$ 80

The total registration fee, payable in advance, includes the cost of instructional materials, coffee breaks, lunches, and reception.

Credits: 20 credit hours in Category I of the Physician's Recognition Award, American Medical Association, for the entire course.

Supported by an educational grant from Pfizer Medical Systems, Inc.

October 11, afternoon

Moderator: Krishna C.V.G. Rao, M.D.

Functional CT Anatomy — Mokhtar H. Gado, M.D.

Sensitivity and Specificity of CT Scanning in Intracranial Neoplasm — Sadek K. Hilal, M.D., Ph.D.

CT in Sellar and Parasellar Lesions — Fred J. Hodges, III, M.D.

Normal and Abnormal CT Anatomy of Intracranial Structures — Sadek K. Hilal, M.D., Ph.D.

October 12, morning

Moderator: Richard F. Mayer, M.D.

CT in Stroke — Irvin Kricheff, M.D.

Intracranial Anomalies — Derek C. Harwood-Nash, M.D.

CT in Certain Pediatric Conditions — Krishna C.V.G. Rao, M.D.

Moderator: Harvey H. Levine, M.D.

CT in Head Trauma — Pulla R.S. Kishore, M.D.

CT in Degenerative Brain Disease — Giovanni DiChiro, M.D.

CT in Infection — S.H. Lee, M.D.

October 12, afternoon

Moderator: Thomas B. Ducker, M.D.

Computed Tomography/Metrizamide in Evaluation of

Pediatric Spine — Derek C. Harwood-Nash, M.D.

CT/Metrizamide in the Adult Spine — Mokhtar Gado, M.D.

Use of Metrizamide and Alternative Methods of Evaluating Posterior Fossa Lesions — Irvin Kricheff, M.D.

Recent Trends in Neuro-imaging Modalities — Giovanni DiChiro, M.D.

Moderator: Giovanni DiChiro, M.D.

Panel Discussion

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Doctors in the News

Dr. Johnson Honored

Dr. Eliot W. Johnson, a family practitioner who for the past 52 years has served the medical needs of thousands of Baltimoreans, was honored with a retirement testimonial dinner at Martin's West in Baltimore County recently for his over half-a-century of dedication.

Operating his practice from his office at 3432 Frederick Rd. in Baltimore for most of his 52 years in medicine, Dr. Johnson has been noted for his involvement in the proceedings that led to the canonization of St. Elizabeth Ann Seton, the first American-born saint. He also holds the distinction of being the first medical resident at Baltimore's St. Agnes Hospital, operated by the Daughters of Charity.

Born and raised on a 1,000-acre farm 25 miles south of Raleigh, NC, Dr. Johnson attended the University of North Carolina at Chapel Hill and went on to obtain his Medical Degree from the Medical College of Virginia. In June, 1923, he was accepted as the first medical resident at St. Agnes Hospital.

Following his residency, which covered not only medicine but also obstetrics, Dr. Johnson established his practice in southwest Baltimore.

One of Dr. Johnson's most distinguished cases involved Severna Park resident Mrs. Anne O'Neill Hooe. In her preteen years, Mrs. Hooe was stricken with a severe case of Leukemia. The girl's parents brought the child to Dr. Johnson, who had delivered her. He referred her to Dr. Milton Sachs head of the Department of Hematology at the University of Maryland Hospital. Dr. Sachs administered experimental medication to the girl, but the response was negligible and her condition worsened. She was admitted into the St. Agnes Hospital pediatric floor, where one of the Daughters of Charity, the Catholic order of nuns who founded St. Agnes Hospital, initiated a novena to Elizabeth Ann Seton to restore the girl's



DR. JOHNSON

health. Soon afterward the young girl's condition began to improve, and today she lives comfortably with her husband and children, having no recurrence of the disease to date.

This healing was determined to be a miracle following an investigation of the authenticity of the event, at which time Dr. Johnson's testimony was used as evidence. The healing served as the second miracle of three performed through Mother Seton. On Sept. 14, 1975, Pope Paul VI canonized Elizabeth Ann Seton as the first American-born saint. Mrs. Hooe attended the ceremony.

Dr. Schanno Appointed

Joseph F. Schanno, MD, Bethesda, has been appointed as a Governor of the American College of Angiology for Maryland for the year 1979-80.

Dr. Williams Named

Dr. Ralph H. Williams of Hagerstown will be named a Fellow of the American College of Radiology at its Annual Meeting in Chicago Sept. 19th. A 1954 graduate of the Jefferson Medical College of Thomas Jefferson University in Philadelphia, Dr. Williams is affiliated with the Washington County Hospital and the Brooklane Psychiatric Center, both in Hagerstown, as well as the VA Center in Martinsburg, WV.

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PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.

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ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977
U.S. Patent 2,985,558

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for Knotts in the night



QuinammTM

each tablet contains quinine sulfate 260 mg , aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
- Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

Second Conference on the Canadian Health Care System, Toronto, Ontario, November, 1978

By ELZA DAVIS

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A seminar was sponsored by the American Medical Association and conducted by Hickling-Johnston, Ltd., Management Consultants in November, 1978 to provide leaders of the medical profession with a firsthand experience of the Canadian Health Care Service and to review its development, accomplishments and problems. The focus of the program was on the government-financed health care system and its relevancy to the restructuring of the American system of health care and was held in Toronto, Ontario.

Background

The Canadian system as it exists today was born of concern on the part of the public for better and more available health services boosted by the increasingly-popular political ideal of universal medical coverage. The program was implemented in two stages: the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966-67.

As early as the 1920s, commercial sickness and accident insurance policies were available to Canadians! "The first government-sponsored medical-hospital insurance plan in North America was introduced in Newfoundland in 1934.¹ In the late 1930s, several forms of voluntary insurance programs were implemented, including prepaid provincial medical association insurance programs and not-for-profit Blue Cross plans. In the Western Provinces, particularly, local governments were used to sponsor programs to pay for hospital care. In these sparsely-populated areas, local government agencies acted as pay agents for the needy. They raised funds locally by special taxes earmarked for health care. Hospital pre-payment plans were sponsored in mining and lumbering communities with funds raised through public celebrations and the sale of "tickets" for care to be rendered. By 1945, the Advisory Committee on Health Insurance prepared a report leading to the first concrete proposals by the Federal government for a comprehensive, nationwide health insurance program. In 1948, the Federal government established a system of Federal grants-in-aid to finance health care which was described at the time as "A fundamental prerequisite of a nationwide system of health insurance."² The grants-in-aid program served to bolster the Provincial plans which were facing physical plant depletion and diminishing personnel.

By 1956, a Federal proposal was made in which "Priority of attention should be given to the development of plans to cover diagnostic service and hospital care, and that only after the establishment of some form

of hospital insurance, should further consideration be given to what additional steps should be taken."³

The Federal Hospital Insurance and Diagnostic Services Act was passed unanimously by the House of Commons on Apr. 12, 1957 and implemented on July 1, 1958.

With the hospital insurance program in operation, the Federal government turned its attention to medical services. The Canadian Medical Association requested that a Royal Commission study the health field. The request, dated Dec. 12, 1960, sought in part, an assessment of "The health needs and resources of Canada with a view to recommending methods of ensuring the highest standard of health care for all Canadians . . ."⁴ The Medical Association not only declared its official position in this document, but offered its full cooperation in any forthcoming undertaking. Following the course of development for the hospital insurance plan, medical insurance plans were implemented on a provincial basis. Saskatchewan, the only Socialist government in Canada at that time, was the first to establish such a plan. A great deal of negotiating and hard bargaining, including a strike by physicians, finally culminated in the Saskatoon Agreement of 1962. The Agreement provided for universal medical coverage paid by the provincial government. Physicians had the option to bill the plan for their services, or to bill the patient directly with the patient collecting from the plan. The Federal Medical Care Act was introduced in 1965 and was followed by a period of controversy between the medical profession and the Federal government regarding the conditions of entry into the government plan. The Act was passed in December, 1966 and became effective on July 1, 1968.

Benefits of the Government Health Insurance Plans

In Canada, both necessary medical care and hospitalization are provided without limit to all who are qualified subscribers. The programs are administered on an individual basis by each province with a combination of Provincial and Federal funds. Provinces must meet minimum standards to participate in the plans. Minimum criteria are given in Table 1.

To be a qualified subscriber, a person must have been a resident of the Province for at least three months. Physicians are free to locate anywhere in Canada. If the physician is paid through the government insurance mechanism, the fee is negotiated on a periodic basis with the Provincial Medical Association. The government pays between 80%-90% of the negotiated fee schedule. If the physician elects to "opt-out" of the system, he/she may charge the patient whatever fee he/she deems appropriate. He/she must

inform the patient he/she is not a participating physician and the amount of fee expected. The patient may then elect to stay with the physician, paying him/her directly and collecting the scheduled amount from the government, or the patient may look for a participating physician. About 90% of all physicians participate in the government plan. Hospitals remain private institutions governed in much the same way as hospitals in the United States, with Boards of Directors.

Financing of the Canadian National Health Insurance

Direct control of financing the health plans rests with each Provincial government. Funds come from general tax revenues, premium payments (paid either by

employer or individual or both) earmarked income tax surcharges, payroll tax, co-payments or a combination of many. The exact services provided varies among the Provinces. A partial summary of the benefits offered and premium requirements is given in Table 2; - Summary of Provincial Health Care Plans.

In addition to Provincial financing of the health insurance plans, until 1977, the Federal government supported the Provincial hospital programs on the basis of 25% of the national per capita cost of in-patient services and 25% of the per capita cost of in-patient services in each Province. This percentage-sharing arrangement means high cost Provinces receive a lower percentage of their costs from the Federal government and low cost Provinces receive a higher share. The more a Province's costs exceed the national costs, the lower is the percentage of the Federal contribution. Hospital insurance provides for basic ward care in-hospital. For patients desiring semi-private or private rooms, the difference may be paid out of pocket, or through additional private insurance plans. The medical plans were partially-financed by the Federal contributions based on half the national average per capita cost of insured services multiplied by the average number of insured persons in each Province.

Beginning with the 1977-78 Fiscal Year, the Federal government discontinued the open-ended cost-sharing mechanism with the Provinces. In an effort to protect the Federal treasury from escalating health costs, the Federal arrangement is now called Established Programs Financing (EPF). Under this provision, the Federal government transfers tax credit points to the Provinces and supplements with fixed per capita grants tied to the Gross National Product (GNP) the responsibility for financing is effectively switched from Federal to Provincial control.

Canadian Health Insurance — Today and Tomorrow: Hospitals

The focal point of health care in Canada is the hospital. Even before the passage of the Hospital Insurance and Diagnostic Services Act of 1957, the Federal government was supporting hospitals through the grants-in-aid program. During the years 1948-66, Federal grants were made to the Provinces in the total amount of approximately \$824,378,000 to be used for various purposes including hospital construction, laboratory and X-ray services, cancer control and others.⁵ The implementation of the universal insurance program brought with it an increased demand for hospital services. The decade of the 1960s saw the closing of smaller, inefficient hospitals and the expansion of large and moderately-sized institutions. During the period 1961-72, bed-population ratio rose from 6.6 to 6.9 per 1,000.⁶ Medical staffs expanded to meet increasing needs from 12.65 personnel hours per patient-day of hospitalization in 1961 to 14.63 hours in 1972.⁷ Canadian hospitals are managed in much the same way as American hospitals, with a Board of Directors and a hospital administrator responsible to the Board. Staffing is open with physicians applying for privileges.

Table 1: Minimum Criteria for Federal Grant Eligibility Hospital Insurance and Diagnostic Services, 1957

1. Accommodations and meals at the standard or public ward level.
2. Necessary nursing service.
3. Laboratory, radiological and other diagnostic procedures, including the cost of professional interpretations where they are essential.
4. Drugs, biologicals and related preparations as provided in an agreement when administered in a hospital.
5. Use of operating room, case room and anesthetic facilities, including necessary equipment and supplies.
6. Routine surgical supplies.
7. Use of radiotherapy and physiotherapy facilities where available.
8. Services rendered by persons who receive remuneration therefore from the hospital.
9. Such other services as are specified in an agreement.

Medical Care Act, 1967

1. Comprehensive coverage for all medically-required services rendered by a physician or surgeon. There can be no dollar limit or exclusion except on the grounds that the services were not medically-required. The benefit coverage must be administered in such a way that there will be no financial impediment or preclusion to an insured person receiving necessary medical care. Certain surgical/dental services rendered by dental surgeons in hospitals have been included as benefits from July 1, 1968.
2. Universal availability to all eligible residents of a participating province on uniform terms, conditions and covering; in addition, at least 95% of the total eligible population. This ensures access to coverage by all residents and prevents premium discrimination on account of previous health, age, non-membership in a group of other consideration. At the same time, subsidization in whole, or in part, for certain age groups or low-income groups is permitted, if a plan is financed by means of a premium system, provided all qualifying residents are treated equally.
3. Portability of benefits when the beneficiary is temporarily absent from his own Province and when he is moving from one participating province to another. It is not related to employment insurance groups and, consequently, coverage, is not lost when an individual changes jobs or residence.
4. Administration on a non-profit basis by a public authority which is accountable to the provincial government for its financial transactions.

Source: Health and Welfare, Canada

TABLE 2: Summary of Provincial Health Care Plans

PROVINCE AND DATE OF ENTRY	ANNUAL PREMIUM	HOSPITAL BENEFITS COST SHARED	AUTHORIZED CHARGES FOR HOSPITALIZATION	EXTRA BENEFITS (MEDICAL CARE)	EXPENDITURES . . ON
					1) MEDICAL CARE 2) HOSPITAL CARE (1976-77)
British Columbia July 1, 1968 (Med. Care) July 1, 1958 (Hosp. Ins.)	Single \$ 90 Couple \$180 Family \$225 (Full rates)	In-patient: standard ward and all approved available services. Out-patient: emergency services, minor surgical procedure, day-care surgical services, out-patient cancer therapy, psychiatric day care and night care services, day care rehabilitation services, narcotic addiction services, physiotherapy services, diabetic day-care, and specified out-patient psychiatric services (in designated hospitals). Also dietetic counselling and cytology services, renal dialysis treatments.	a) \$4 per day for standard ward care for adults and children, excluding newborn. b) \$2 for each emergency or minor surgical out-patient treatment. c) \$2 for day care surgical services. d) \$1 for out-patient cancer therapy. e) \$1 for psychiatric day care or night care and psychiatric out-patient services. f) \$1 for out-patient physiotherapy services. g) \$1 for diabetic day care services. h) \$1 for day care rehabilitation services. i) \$6.50 per day for adults and \$1 per day for children under the age of nineteen in extended care hospitals.	Optometry, chiropractic, naturopathy, physiotherapy, podiatry, orthoptic treatment and services of Red Cross nurses, special nurses and V.O.N. Orthodontic services for cleft palate and/or harelip. (Free prescription drug program for residents over 65 and a drug subsidy program for those under 65, the handicapped and the chronically ill, and a universal Pharmacare plan which protects individuals from financial hardship as a result of high prescription drug expenses).	1) \$254 million 2) \$554 million
Alberta July 1, 1969 (Med. Care) July 1, 1958 (Hosp. Ins.)	Single \$ 91.80 Family \$183.60 (Full rates)	In-patient: standard ward and all approved available services. Out-patient: 100% of all out-patient procedures rendered by the hospital, 100% of all diagnostic and physiotherapy services rendered in approved facilities outside the hospital, 100% of all out-patient services provided by provincial cancer clinics and provincial laboratories, dietetic counseling services, extensive home care benefits.	Adults and children, excluding newborn: \$5 for the first day in active treatment hospitals. Auxiliary hospitals: \$5 per day after 120 days.	Dental services rendered by dental surgeons as specified in regulations, optometric and chiropractic services and podiatric services and appliances. An optional health services contract is available through the commission providing Alberta Blue Cross plan membership at reduced rates to residents who are not members of a group. For residents over 65 and their dependents, the government provides a major portion of the cost of eyeglasses and assumes the cost of hearing aids, dentures and dental care and medical and surgical equipment, supplies and appliances.	1) \$149 million 2) \$420 million
Saskatchewan July 1, 1968 (July 1, 1962) (Med. Care) July 1, 1958 (Hosp. Ins.)	No premium	In-patient: standard ward and all approved available services. Out-patient: to the extent that a hospital is able to provide it.	None	Optometry, chiropractic, referred services by dentist for care of cleft palate and for orthodontic oral surgery. Subsidized hearing aid program, provision of prosthetic and orthotic devices, wheelchairs, walkers, commodes and other aids to daily living, a dental plan for children and a prescription drug plan.	1) \$65 million 2) \$197 million
Manitoba Apr. 1, 1969 (Med. Care) July 1, 1958 (Hosp. Ins.)	No premium	In-patient: standard ward and all approved available services. Out-patient: all services except drugs and dressings in certain cases. Extensive nursing home benefits.	None	Optometry, chiropractic, prosthetic devices and certain limb and spinal orthotic devices and services when prescribed by an M. D. Contact lens following congenital cataract surgery. Artificial eyes. Personal care and special devices programs. Pharmacare program that covers all persons. — \$50 deductible per family or individual — 85% of cost of prescriptions is paid by the plan after deductible — drugs covered are most drugs except OTC	1) \$74 million 2) \$232 million (Continued on next page)

(TABLE 2 Continued)

PROVINCE AND DATE OF ENTRY	ANNUAL PREMIUM	HOSPITAL BENEFITS COST SHARED	AUTHORIZED CHARGES FOR HOSPITALIZATION	EXTRA BENEFITS (MEDICAL CARE)	EXPENDITURES . . . ON 1) MEDICAL CARE 2) HOSPITAL CARE (1976-77)
Ontario Oct. 1, 1969 (Med. Care) Jan. 1, 1959 (Hosp. Ins.)	Single \$228 Family \$456	In-patient: standard ward and all approved available services. Out-patient: broad range of essential services, physio-occupational, speech, radio-, and inhalation therapies, and other hospital services when medically necessary. Where available the provision of quipment, supplies and medications for use in the home by haemophilic patients for the emergency treatment or the prevention of haemorrhage; extensive nursing home benefits.	None	Optometry, chiropractic, chiropody, podiatry, osteopathy and specified dental services performed in hospital (also out of hospital benefit towards cost of physiotherapy and for ambulance services) Home Care Program Services, home renal dialysis and home hyperalimentation equipment, supplies and medication. Free Drug Benefit Plan for persons 65 years and over, disabled persons and persons with limited incomes.	1) \$717 million 2) \$1,873 million
Quebec Nov. 1, 1970 (Med. Care) Jan. 1, 1961 (Hosp. Ins.)	No premium 1.5% of earnings in-come tax sur-charge (plas-tic registr cards) also 1.5% of total salaries paid by employer. Maximum surcharge is \$235 (1977)	In-patient: standard ward including all available services. Out-patient: certain psychiatric services, emergency (24 hrs.), minor surgery including X-ray and laboratory examinations and related interpretation, physiotherapy, radiotherapy, medical orthotics, occupational therapy audiology and speech therapy, services or examinations necessary to obtain employment, or required during the course of employment, or as requested by the employer.	Charges are \$7 per day in extended care hospitals and in extended care units in short-term care hospitals. Children under the age of 18 are exempt. Low income individuals may benefit from total or partial exemption depending on their income.	Optometry, oral surgery in a university institution. Drug benefit. (Social assistance recipients and beneficiaries of the maximum old age pension and supplement). Functional aids for the visually handicapped under eighteen years. Dental services for children under fifteen.	1) \$532 million 2) \$1,451 million
New Brunswick Jan. 1, 1971 (Med. Care) July 1, 1959 (Hosp. Ins.)	No premium All eligible residents	In-patient: standard ward and all approved available services. Out-patient: all approved available services.	None	Prescription Drug Program for those 65 years and over and for those with cystic fibrosis.	1) \$39 million 2) \$145 million
Nova Scotia Apr. 1, 1969 (Med. Care) Jan. 1, 1959 (Hosp. Ins.)	No premium 8% health service tax	In-patient: standard ward and all available services. Out-patient: broad range of essential services as approved by regulation including: medically necessary laboratory, electroencephalographic and radiological examinations, radiotherapy for malignant and non-malignant conditions, electrocardiograms, physiotherapy facilities where available, various drugs, hospital services including meals for day patient care for diabetes, hemodialysis, ultrasonic diagnostic procedures and interpretations and electrocardiograms and interpretations, as well as various emergency diagnoses and treatment within 48 hrs. of an accident and various hospital services in connection with various minor medical and surgical procedures.	None	Optometric visual analysis; Dental plan for children born after January 1, 1967, or for students registered with The School for the Blind. Pharmacare plan for residents 65 years and over, diabetes incipitus drug program; cystic fibrosis program; Rare lip/cleft palate dental program. No charge.	1) \$65 million 2) \$174 million

(TABLE 2 Continued)

PROVINCE AND DATE OF ENTRY	ANNUAL PREMIUM	HOSPITAL BENEFITS COST SHARED	AUTHORIZED CHARGES FOR HOSPITALIZATION	EXTRA BENEFITS (MEDICAL CARE)	EXPENDITURES . . ON 1) MEDICAL CARE 2) HOSPITAL CARE (1976-77)
Prince Edward Island Dec. 1, 1970 (Med. Care) Oct. 1, 1959 (Hosp. Ins.)	No premium All eligible residents	In-patient: standard ward and all approved available services. Out-patient: laboratory procedures as specified, radiological procedures as specified, including use of radioactive isotopes; drugs, biological and related preparation for emergency diagnosis and treatment, all other services specified as in-patient services.	None		1) \$8 million 2) \$20 million
Newfound- land Apr. 1, 1969 (Med. Care) July 1, 1958 (Hosp. Ins.)	No premium All eligible residents	In-patient: standard ward and all approved available services. Out-patient: laboratory, radiological, and other diagnostic procedures, including the necessary interpretations, radiotherapy and physiotherapy, where available, occupational therapy, where available, out-patient visits, emergency visits, operating room facilities including supplies, plaster casts, drugs and medical and surgical supplies administered in hospital.	None	Chi'dren's Dental Health program available to children up to 11 years of age. This program is administered by the Department of Health at no charge.	1) \$32 million 2) \$124 million Participating physicians accept plan payment as payment in full but a participating specialist, subject to similar conditions applicable to opted-out physicians, may charge a nonreferred patient for differential, if any, between the plan payment and what he would otherwise have received in respect of his services if the patient had been referred to him by another physician.

Source: Canadian Medical Association, Ottawa, Ontario, 1978

Hospitals maintain a universal system of accounting. Budgeting for hospitals is done on a prospective basis, which is termed "global budgeting." A hospital receives a sum of money based upon a negotiated figure with a certain percentage increase each year. No additional public funds are added to the budget during the year. The hospital has full control over the allocation of the funds. If the hospital incurs a justifiable deficit, it may be awarded a supplementary grant by the Province at the end of the year. Profits may be retained, although, it might lead to a lower budget for the succeeding year. The hospital budget is reviewed by the provincial government which, in turn, sets the per diem rates for each hospital. Over the past few years, the hospital base figure has been shrinking until it is now below the current rate of inflation. Funds for construction of new and replacement health facilities, for training and research facilities come from the Health Resources Fund. These funds are not tied to the global budgets of hospitals. Among teaching hospitals, the available funds are divided among the applicants and systems of shared services are encouraged. In large teaching hospitals, all patients are potential teaching patients with very few exceptions. Major equipment replacement must be put into the global budget and often takes several years to accomplish. Some hospitals do have endowment funds available and sometimes these are used

for this purpose.

Purchases of major new equipment, such as CAT scanners, comes under the jurisdiction of the health planning authorities in each Province called District Health Councils. These councils which are somewhat like the Health Systems Agencies in the US were established to gain more control over the expenditure of health care dollars.

The strong emphasis on the hospital as the key to the health care delivery system from the beginning has had the effect of stifling the development of alternatives. As a result, for example, there are far too few nursing home or extended care beds to serve the population. Thus, patients remain in hospitals often far longer than necessary.

Physicians

Until recently, physicians generally have been pleased with the system of health insurance as it exists in Canada. They were instrumental in the early planning stages, and have become used to dealing with the government as the third-party payor. About 90% of all physicians nationwide practice within the health care system, being paid by the government for their services on a fee schedule basis. Fee schedules are negotiated in each Province by the Provincial medical society. Payment is approximately 80%-90% of the fee schedule, which is renegotiated annually in some

Provinces and less often in others.

Physician to population ratio in Canada is approximately 1:633.⁸ Just as in the US, an anticipated shortfall of physicians led to increased training, now, followed by a possible overproduction. A large number of Foreign Medical Graduates have immigrated to Canada over the past 30 years, many of them from the United Kingdom. There is now a movement to limit the number of foreign physicians coming into the country. Also, as in the US, the problem of distribution still remains. The major medical centers have the highest proportion of physicians, with the rural areas still under served. Incentive programs have been organized to attract physicians to these areas. Student physicians are being encouraged to enter family practice rather than other areas of specialization.

In most Provinces, specialty certification is through either the Royal College of Physicians and Surgeons or the College of Family Physicians. Physician discipline is maintained in different ways for each Province. In each hospital, there are mechanisms for peer review, such as tissue committees. In addition to the physicians' competency, his/her practice is continually reviewed by Provincial health insurance commissions. The physicians' statistical profile is maintained and his/her billing practices closely-scrutinized. Patients are sent periodic statements of fees paid on their behalf with comments requested as to the accuracy of the billing.

Initially, physician reimbursement under the Medical Care Act (Medicare) was thought by most to be equitable. Physicians were the negotiating body for the establishment of the fee schedule and had major input into the system. As fiscal pressures increased, the rate of increase in the fee schedule has slowed to well below the rate of inflation. Thus, physicians find themselves further and further behind in the payment scale. In 1971, average net earnings of physicians in Canada were \$39,200.⁹ This amounts to approximately 6.5 times the income of the average employee.

Other Health Professionals

Nurses in Canada are unionized in hospitals and have successfully negotiated favorable contracts over the recent past and have managed to raise their salary levels to a favorable position. Most nurses are graduates of two-or three-year training programs. Most nurses are diploma nurses with far fewer going into specialty training programs—either Baccalaureate degree or post-basic certificate programs; however, with rising costs, greater encouragement is now being given nurses to enter programs for Nurse Practitioners and Nurse Midwives.

The equivalents of Licensed Practical Nurses are called Certified Nursing Assistants in Canada. Educational requirements include completion of grades 9, 10 or 11, followed by a training program in hospitals or community colleges. These nurses perform fewer functions than do LPNs in the US.

Dentists are a major segment of the health service package. Dental care is included under the gov-

ernment program in many of the provinces. (See Table 2.) A program is currently underway to increase manpower in this area. In the past, some of the work of the dentist has been handled by specially-trained dental nurses. These nurses work often in the public schools and have provided dental services to a greatly-underserved population. Overall poor dental health of Canadians has given rise to some innovative projects which have somewhat alleviated the problem.

Other major allied health professionals in Canada include laboratory and X-ray technicians, rehabilitation therapists (a combination of occupational and physical therapy), pharmacists and chiropodists, of which there are extremely few.

Professional Liability

Canadian physicians pay approximately \$35 per year for membership in the Canadian Medical Protective Association. "Membership in the Association entitles a physician or surgeon to legal advice, legal representation in liability claims, and indemnification for damage awards that may be granted against him."¹⁰ Nuisance suits are not considered and expert witnesses are not paid fees except in very unusual circumstances. Physician members of the Association are expected to become defense witnesses. The Association provides the attorney to represent the physician, pays all damages and costs assessed against the physician as well as any appeals that are appropriate. In Canada, the claimant does not have the right to a jury trial. The trial is heard by a judge. The losing party in the suit pays the costs of the winning party, including reimbursement for attorneys' fees. Canadian attorneys are not permitted to represent a client on a contingent fee basis. Substantial awards for pain and suffering are rare.

Research

The funds for research activities in Canada are rapidly drying up. Some projects still exist through private grants. The very scarce resources available from the government must be shared between teaching and community hospital. Physician directors of research projects often engage in that activity without compensation, deriving their income from other sources—salaries as staff physicians mainly. Some physicians feel the quality of teaching in the medical schools will eventually take a step backward in time.

Ontario

The focus for the seminar was the province of Ontario, and it is appropriate to detail here some of the conditions in Ontario which may or may not exist in other provinces, but which mirror the general trends of Canada.

Two hospitals were visited and the vital statistics for each follow. The first, York County Hospital in Newmarket, is a suburban facility. It has been entirely-modernized and updated with new facilities added. The pathology laboratories have been constructed with an eye toward future expansion. The laboratory appeared to be operating at less than one-

third potential capacity. The laboratory is administered by an administrator who also is a trained laboratory technician. Under his charge are the staff technicians. He works in conjunction with the medical director of the laboratory and has full responsibility for the physical functioning of the facility.

This hospital has a very large in-patient psychiatric department. The psychiatrist in charge spent part of his time at the hospital and part-time in his private practice. He identified a shortage of psychiatrists in that area. A sizable portion of his time is spent in consultation with family physicians who refer patients for his evaluation and who then resume management of the patient if appropriate. (Full in-patient and out-patient psychiatric benefits are provided under the Ontario Health Insurance Plan—OHIP.)

There is currently a waiting period of about three weeks for elective surgery in this facility, and many perceive the time is growing longer. Part of the problem seems to be the lack of alternative care facilities into which patients might be moved. (See Table 3 for hospital statistics.)

The second hospital visited was Toronto General Hospital, a major inner-city teaching hospital. It is

not unlike many big city hospitals and was in the process of a major construction project. Two of the old sections of the hospital were to be torn down, while an extensive new addition was being constructed. The cardiac catheterization laboratory was located in a former greenhouse. The corridors were filled with equipment. The machinery, we were told, had been repaired and rebuilt by the hospital maintenance staff lacking funds for replacement equipment. With the new construction, this facility will be moved and new equipment purchased. Many of the staff physicians hold teaching positions with the hospital and are on salary. Teaching salaries have been declining in recent years. Nevertheless, most professionals on staff expressed satisfaction with the situation. (See Table 4 for hospital statistics.)

Ontario health premiums are the highest in Canada. The annual cost of the Ontario Health Insurance Plan (OHIP) is now \$528 per annum for a family of three. The rising cost of health insurance is reflected in other provinces as well. In its 1977-78 Annual Report, the Ministry of Health of Ontario shows a total revenue of \$914,016,052 and an excess of expenditure over revenue of \$2,766,092,949. The total revenue reflects contributions from the Government of Canada. The report is silent on the source of funds for the deficit. (See Table 5.)

Table 3: York County Hospital—Newmarket, Ontario

York County Hospital is a lay-public/general hospital established in 1922. The hospital serves the northern portion of the Regional Municipality of York. This catchment area covers some 700 square miles with an estimated population of 100,000.

Approximately 40% of the hospital admissions are from the towns of Newmarket and Aurora, 20% from the township of Georgina, and 20% from other areas of the Region; 15% come from the County of Simcoe and another 5% also come from outside the Region.

Some Basic Statistics:	Number of Beds	Average Length of Stay
Medical-Surgical	186	7.5 (Active)
Obstetrical	30	Number Admissions/Year 12,343 (Active Long-Term)
Paediatric	28	
Psychiatric	30	
Intensive Care—		
Coronary Care	14	157,000 (Out-Patient Visits)
Continuing Care	58	
TOTAL:	346	
POTENTIAL CAPACITY:	419	

Medical Staff

Active and Associate	72	(Information Supplied by: Hickling-Johnson Management Consultants, Second Conference on the Canadian Health System November, 1978)
Consultant	21	
Courtesy	13	
Dental	12	
Honorary	5	
TOTAL:	123	

Employees

Full-Time	675
Part-Time	325
TOTAL:	1,000

TOTAL BUDGET:

Hospital	\$14,000,000	Educational	\$30,000
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Table 4: Toronto General Hospital

Toronto General Hospital is a major teaching hospital located in the downtown core of Metropolitan Toronto. This lay-public/general hospital was established in 1820 to serve the needs of what was then York. The hospital has continued to expand to provide the ever increasing population of Toronto and surrounding areas with first class medical care and to provide a stimulating and research-oriented environment for its medical personnel.

Some Basic Statistics	# of Beds	Average Length of Stay
Surgical	416	10.4
Medical	343	
Intensive Care	61	Number Admissions/Year
Obstetrical	57	31,692 (Active & Long-Term)
Gynecology	80	134,614 (University Clinics)
Psychiatry	38	
Paraplegic	9	
Ophthalmology	47	
Otolaryngology	32	
Dentistry	6	
Total:	1,089	Total Budget:
Bassinets	88	Hospital: \$75,356,000
		Educational: \$6,734,000
Medical Staff		
Consultant/Active/ Courtesy and Associate	581	(information Supplied by: Hickling-Johnson Manage- ment Consultants, Second Conference on the Canadian Health System November, 1978)
House Staff (Medical)	225	
Hospital Staff		
Nursing	1,417	
Professional and Technical	478	
General Service	1,355	
	3,250	

Table 5:

Ministry of Health staff strength

	March 31, 1977	March 31, 1978
Full-Time		
Psychiatric facilities	8,530	7,785
Branches	4,729	4,534
Total	13,259	12,319
Part-Time		
Psychiatric facilities	612	556
Branches	78	79
Total	690	635
Combined Total	13,949	12,954
Statement of Revenue and Expenditure for the year ended March 31, 1978		

Expenditure

Ministry administration and Health Insurance Program

Main office	\$ 3,632,529
Financial services	4,506,984
Supply and office services	6,071,482
Personnel services	1,229,222
Information services	1,697,129
Analysis and planning	175,967
Legal services	392,966
Audit services	1,007,294
Research	19,115,780
Systems and statistical data	12,079,812
Health insurance	930,502,175
Drugs and therapeutics	73,605,968
Total	\$1,054,017,308

Institutional Health Services Program

Program administration	\$ 2,334,766
Direct services — administration	13,994,310
Psychiatric services	203,943,693
Ambulance services	47,781,627
Laboratory services	12,576,952
Institutional care services	2,236,221,635
Total	\$2,516,852,983

Community Health Services Program

Program administration	\$ 3,248,590
Personal health services	29,437,340
Community health services	76,552,780
Total	\$.. 109,238,710
Total expenditure	\$3,680,109,001

Revenue

Contributions:	
Government of Canada	\$ 52,055,467
Premiums:	
Ontario Health Insurance Plan	829,934,952
Miscellaneous	32,025,633
Total Revenue	\$ 914,016,052
Excess of expenditure over revenue	\$2,766,092,949

(Source: Ontario Ministry of Health, Toronto, Ont. Canada)

Physicians in Ontario have become increasingly frustrated with the bargaining mechanism. The Ontario Medical Association is the bargaining agent for the physicians. They feel the exercise is merely one of determining what level the government will pay for the coming year. Increases have been approximately 4% per year, or below the inflation rate.

Prior to May 1, 1978, OHIP benefits were set at 90% of the OMA Schedule of fees. As of May 1st, however, OMA revised the fee schedule to indicate to physicians what appropriate fee levels would be in order to restore physicians' incomes to their position prior to the imposition of income controls. OHIP ruled the resulting suggested fees were too high to continue the 90% reimbursement ratio and established, for the first time, its own schedule of benefits.

Table 6 is a Comparison of Fee Schedules for Selected Procedures compiled by the AMA. The Table lists both the OMA suggested fee and the Ontario Health Insurance Plan fee as compared with Medicare payments for Cook County, IL.

Indications for the Future

Of the 24 speakers who addressed the seminar, only a very few expressed total dissatisfaction with the system. One indicated plans to leave the country. Most agreed they felt the Canadian system is the best that can be found anywhere in the world today. All, however, expressed a growing degree of frustration with the system as it now must respond to severe economic pressures unknown a decade ago.

Canada, like the US, is feeling the effects of increasing inflation and shrinking dollar values. The crunch has been long in coming to Canada; thus the weaknesses in the system have taken much longer to identify. In the years 1960-78, health care costs have risen from 5.5% of the GNP to 7%. At the same time in the US, the percentage has gone from 5.2% to 9%.

Governments both Federal and Provincial are beginning to wrestle with the problems they face within a system which provides everything to everybody. The notion that unlimited health care freely available is a basic human right seems to have been an underlying factor in the establishment of the Canadian health system. While an attractive idea in principle, the philosophy carries with it no individual responsibility. Thus, society as a whole assumes the responsibility for the health care of each individual, including those who freely abuse their health. This fact has led to a new government concentration on healthier lifestyles for individuals. In a treatise entitled *A New Perspective on the Health of Canadians: A Working Document*, Marc Lalonde, Minister of National Health and Welfare of Canada observes "The ultimate philosophical issue raised . . . is whether, and to what extent, government can get into the business of modifying human behavior, even if it does to improve health."¹¹ The document attempts to answer the question raised.

The Minister has prepared a very elaborate plan for altering the lifestyle of Canadians aimed at all sections of the society. He proposes to enlist the aid of

Table 6: Comparisons of Fee Schedules Selected Procedures

	Medicare Prevailing Charge Cook County, IL	Ontario Medical Association	Ontario Health Insurance Plan
Initial Office Visit, GP	\$27.10	\$ 30	\$ 22.50
Initial Office Visit, Specialist	35	—	—
Initial Hospital Visit, GP	33.90	30	22.50
Initial Hospital Visit, Specialist	47.50	—	—
Appendectomy (Simple), GP	350	135	94.50
Appendectomy (Simple), Specialist	350	170	119
Hemorrhiodectomy, GP	339.25	125	87.50
Hemorrhiodectomy, Specialist	350	155	108.50
Cholesterol Blood Count, GP	7	14 units @ 0.41 =5.74	14 units @ 0.368 =5.152
Cholesterol Blood Count, Specialist	7	—	—

Sources: US Department of Health, Education and Welfare, **Medicare Directory of Prevailing Charges, 1978.**
 Ontario Medical Association, **Schedule of Fees, May 1, 1978.**
 Ontario Health Insurance Plan, **Interim Schedule of Benefits, May 1, 1978.**
 Supplied by AMA, Chicago, IL

the major segments—health professions, scientific community, educational system, business sector and trade unions and others. Working together, it is anticipated they will be able to control health risks and force the individual to accept responsibility for his/her health.

Whether they embrace the principle of behavior modification or not, Canadians must now deal with several major problems which were not clearly apparent when the system was implemented.

- * There are no longer sufficient funds to provide *all* services on an unlimited basis to *all* citizens.
- * New research has been steadily dropping for a lack of funds and is presently at a dangerously-low ebb.
- * The hospital-centered delivery system is too expensive to maintain when no viable alternatives are offered.
- * Hospitals still have very little incentive to operate at peak efficiency, even with the global budgeting system.
- * Physician morale is dropping steadily. It is too early to predict whether this will lead to concrete action such as strike or emigration.
- * There is no economic pressure on the citizen to use the system responsibly.

Lloyd Detwiller, Administrator of the Health Sciences Centre of the University of British Columbia and a leading expert on the Canadian system, observed at the conference, "Our systems have no incentives to encourage the public to use them reasonably. On the contrary, there has been encouragement in the past for people to enter the system for any sniffle, ache or pain that they might have. We are attempting to change this by voluntary persuasion, but the volume of questionable demand continues. Even the producers of health services find it to their advantage not to operate too efficiently and effectively, for there seems to be

a political way of having their deficits and over-development picked up by the prepayment authority. Our health systems have no brakes. People demand care and governments seem to have no option but to pay."¹²

A rather cynical summation of the dilemma and current attempts to solve it are presented in Table 7.

Table 7: "The Nine Dogmas of the National Health Service Religion"

1. The unchecked rise in the cost of medical services is the greatest and most urgent problem of the Occidental societies.
2. Physicians are responsible for this situation: They create the demand for there is no true market in medical services, the consumer having no knowledge of the quality of the product.
3. The medical profession pushes needless medical consumption for its own benefit out of greed and furthermore is given a blank check.
4. Physicians are associated in this conspiracy with the medical-industrial complex.
5. Nationalization of the health industry, including physicians as civil servants, is the only way to rationalize medicine.
6. The first and most important move should be for the state to hire ALL doctors on a salary basis: This would automatically reduce costs drastically.
7. MDs should be reduced in number and replaced by clinical nurses, medics, optometrists, chiropractitioners, podiatrists, acupuncturists, et al. The services of these professionals would surely be adequate and eventually less costly.
8. People should be instructed to solve most of their medical problems themselves.
9. Curative medicine should be curtailed in order to foster the development of preventive medicine.

(The above supplied by Dr. R. Robillard at the 2nd Conference on the Canadian Health Care System, Toronto, November, 1978).

These remarks are those of Raymond Robillard, MD, Past President of the Association of Medical Specialists for the Province of Quebec. Dr. Robillard was instrumental in establishing a physicians' union in Quebec. By June, 1979, all physicians in Quebec will have become salaried. Robillard blames part of the current problems of physicians on their shortsightedness in perceiving the ultimate outcome of a National Health scheme and in their reluctance to become fully-involved with its initial creation and then with its ongoing development.

As in all problems of great complexity such as that facing the Canadian Health System, and those we face in the US, there are no simple solutions. One can, however, learn from the mistakes of others.

Detwiller, again, has some relevant observations. "The greatest challenge of all is to abate consumer demand . . ."12 No matter what controls are imposed by the government, there will never be sufficient resources to fill the need created by a totally prepaid system. He suggests a few key ideas worth careful consideration:

- * Citizen-patient participation in the form of deterrent fees, coinsurance charges or percentage sharing. Without them, we have shown we are unable to discipline ourselves so as to use the system reasonably. Total first dollar coverage must be withdrawn.
- * Need to change public attitude toward care of the body. Proper diet, exercise and health teachings should be given priority in educational programs.
- * Development of a private system of health insurance and care, alongside the government ones. These should not operate at the expense of the government program, but should assume a fair share of problem cases and special risks. Such a system would provide a choice to the public and could remove much of the pressure on governments to meet the continued expanding demand for more and more health services.¹³

•

Physicians attending the conference were given some admonishments to carry away with them. The promise of guaranteed money and convenience of a prepaid government system are seductive. The physician becomes part of the system and loses any ability to alter it. The dynamic interaction in medicine is between the patient and the physician, from treatment through payment. It should be maintained; and, the physicians must be unified. A concerted effort to make and keep the system responsive is essential. For this, physicians must work together. It was acknowledged that Canadian physicians did *not* make such a unified effort and are now feeling the consequences. Canada has provided the US with an excellent example of both excellence and failure. It is an invaluable resource to use in the consideration of any government-sponsored health insurance program, but to adopt its provisions, without modification to address the particular problems faced here, would solve nothing.

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Studying the History of the Development of Professional Ethics in American Medicine

By JOSEPH I. BERMAN, MD, MPH

Dr. Berman is Chief of the Department of Community Medicine of Sinai Hospital of Baltimore, Inc., Balto., MD 21215, where he can be contacted for reprint and other data.

Synopsis

A Fellowship from the National Endowment for the Humanities permitted the author to spend a month intensively studying the history of the development of professional ethics in medicine, together with eight other physicians and two non-physicians. The course presented an opportunity to develop an understanding of the historical facts and precedents leading to our present position on ethical issues. This knowledge can be useful to a physician in helping him/her to better understand the genesis of his/her own ethical ideas, as well as those of his/her profession. Physicians must be prepared to respond to the demands and pressures of a society that is greatly concerned with major ethical dilemmas of the day. Organized, concentrated study of professional ethics will better provide physicians, who may otherwise be unprepared by previous training, to participate in such discussions and to affect their outcome.

The busy physician, striving to maintain clinical excellence in his/her practice is offered a bewildering array of educational opportunities. University medical centers, specialty organizations and travel groups, often combining learning with "fun in the sun," entice the practitioner to sharpen clinical skills. These offerings may not be ignored because of the very real need to maintain these clinical skills and because many states now require a prescribed number of hours of Continuing Medical Education for relicensure. CME appears to be one of the great growth industries in American business today.

The physician must decide on the nature of the subject matter he/she wishes to pursue, and the amount of time that he/she can afford to spend. I am unaware of any formal study of physicians' choices of continuing education subjects, or the relationships of the choice of subject material to the physician's clinical specialty; however, one might intuitively believe that study of the history of medical ethics in American medicine might not be expected to be of major interest to most physicians trying to maintain professional skills and meet licensure requirements. A history of medical ethics, if considered to be of any importance at all, might well be relegated to historians and philosophers.

During this past year, I had the experience of participating in a one-month seminar devoted to the subject of the history of medical ethics in American medicine. The seminar was formally entitled *The Quest for Professional Ethics in American Medicine: An Historical Exploration*. For 20 full working days and many more nights I—together with eight other physicians of diverse

backgrounds and ages, a minister and a nurse—pursued this historical study under the direction of the faculty of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston, TX. The experience, as well as the subject matter, was so interesting that I feel that a brief communication about the course would be appropriate. Despite the need for technical skill and excellence, there are other aspects of the medical profession which might well be studied with value to the individual physician as well as the community at large.

The National Endowment for the Humanities

The National Endowment for the Humanities is an independent Federal grant-making agency created by Congress in 1965 to support projects of research, education and public activity in the humanities. The humanities are defined very widely in the Act, which established the endowment and include, among other things, subjects concerned with questions of value. Among the many activities of this Federal agency are fellowships and stipends for the professions. The purpose of this latter program is to "Give persons in professions outside teaching an opportunity to stand back from their work and to study the historical, philosophical, social and cultural dimensions of their professional interests."

The Galveston seminar was one of some 27 that were available to professionals from business, law, education and the healing arts. Some dealt with subjects of particular interest to a particular profession and membership was generally restricted to members of that profession. Others were interdisciplinary. Because of the wide disparity in subjects, as well as the fact that each course was given at a different university and by different faculty, no generalizations can be made. My comments refer only to the specific course given in Galveston.

After formal application to the National Endowment for the Humanities, I was awarded a stipend for living expenses to study the history of ethics in American medicine at Galveston.

The Study of the History of Medical Ethics

The course required an almost total immersion in the history of medicine and the development of ethical precepts in medicine. Six hours of classes per day involving lectures and discussion were followed by four-six hours of reading nightly.

Curiously, at a time of ringing ethical debates of physician responsibility in such problems as abortion, the right to die and genetic screening, one finds a great

paucity of work written about the development of ethics in American medicine. No definitive text exists on the subject; therefore, a wide variety of sources were utilized during the course, ranging from the Hippocratic oath to readings of contemporary philosophy. Medical history itself does not stand alone, of course, but relates closely to general history. There was need then for extensive reading in both world history and then more specifically in American history. The characteristics and origins of the American medical profession, inextricably interwoven with the particular social relations of the American colonies and their historical antecedents were explored.

Gradually, an understanding of the major ethical precepts of virtue, duty and justice as they evolved over a period of some 2,000 years developed. The physician as a Christian and as a gentleman, the physician with the need to know disease (a concept arising originally with Galen), the physician with duties and responsibilities for the state of the public's health (the 18th Century concept of Medical Police), the physician's responsibility to see that all should share in the benefits of health care, were carefully traced and developed to the present time.

Of particular interest in the development of American medical ethics was the use of ethical codes beginning with the work of Percival in 1803. The American Medical Association, with its first code of ethics in 1847, attempted to lay out rules of etiquette or proper behavior between physicians, their patients and the general public, at the same time as they attempted to encompass major ethical precepts of the time. Study of the various revisions of the AMA codes in the latter half of the 19th Century and on into the 20th, demonstrated some of the changes in the thinking of the organized profession and in part reflected the necessities and vicissitudes of the times in which they were being written.

The AMA code is now being revised yet again. I find it interesting to review the present code and its latest revisions and to consider the code's usefulness as a document to guide the physician in meeting his/her ethical obligations. A physician who is aware of the origin of these ethical precepts is in a much stronger position to judge their value.

There was ample time for the seminar participants, during their reading and discussion, to think about the basis of their own concepts of ethical behavior and to test these concepts against the ideas of others with similar concerns. We tried to determine the origin of our own ethical beliefs, examining the influences of major factors such as religion, law and personal experience.

At least one major historical lesson became clear to me. The development of concepts of ethical behavior among physicians is a continuing process with long-standing historical origins. Ethical ideas that are taken for granted today, i.e., that the physician ought to care for the mentally-or terminally-ill, or even that the physician ought to be responsible for advising the patient of terminal illness, are of relatively recent vin-

tage and have altered the physician's role and the relationship with patients and the public. The explosion of scientific knowledge which has occurred in the last 125 years has given heavy weight to the ethical precept of the physician as one who must know and understand the science of medicine, but the need to know may have overwhelmed many other major ethical obligations of the profession. Understanding the major changes that have occurred in the past sensitizes one to inevitable and continuing changes in ethical responsibility.

The teaching of medical ethics, as well as the humanities, is for the most part ignored in American medical schools and, indeed, was *not* taught to me during my medical school days. The failure to teach these subjects and the preoccupation of the physician in training and in practice with the need to know facts ill prepares the modern American physician to deal with major questions of ethical duty that are now being asked. The value of the Galveston course lies in its reviewing the development of the basic tenets of the "good physician" and provides understanding of the ethical responsibilities of the medical profession and how these responsibilities fit into the larger scheme of things.

I cannot know now what the long-term benefits of a concentrated course of study like the one offered in Galveston will be on me and my seminar associates. I do feel, however, better equipped to deal with both physicians and non-physician philosophers, social scientists, lawyers and others who are now involved in the further development of professional ethics in American medicine. Those with concerns about the historical development of medicine and its ethical responsibilities might wish to entertain the possibility of laying aside their stethoscopes and scalpels for a short period of time to consider these issues. □

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Gasoline Sniffing Brings Lead Poisoning Hazard

Gasoline sniffers run a risk of serious illness from lead poisoning. Three cases of lead poisoning among individuals who sought a "high" from sniffing gasoline fumes are reported in the Sept. 22nd *Journal of the American Medical Association JAMA*.

Dr. Richard O. Robinson of the University of Kentucky Medical Center in Lexington, reports two cases of organic lead poisoning due to habitual gasoline sniffing. A 14-year-old boy died and a 15-year-old girl recovered from serious illness.

Drs. Knight S. Hansen and Frank R. Sharp of the University of California in San Francisco, report the case of a 27-year-old man who was seriously-ill from lead in the fumes of inhaled gasoline. Say Drs. Hansen and Sharp: "Considering the universal availability of leaded gasoline, its low cost, the relatively-small amount of vapor required to produce intoxication and our drug-oriented society, it is surprising that so few cases of gasoline sniffing with resultant lead poisoning have been reported." □

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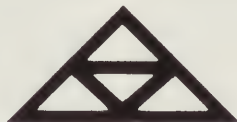
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Comments on Teaching Medical Ethics

By PHILIP FRANKLIN WAGLEY, MD

For reprint and other data, contact Dr. Wagley at 9 E. Chase St., Balto., MD 21202.

Why teach medical ethics? There are various ways one could answer this. The all-encompassing reason is that there are more problems in health care today than there were years ago. More diagnostic techniques are available as are more therapeutic means. Such developments require trained technicians and even teams. Patients and third-party payors, including government, expect more. Physicians' roles have changed. Many have become the technicians and team members. Frequently, while knowing a great deal about the disease-label that patients carry, they know practically nothing about the patients as persons—worried, even frightened human—beings concerned over their disease-label also and what impact their illness will have on their lives and loved ones. Naturally, this may lead to a strong desire for some role in the decision-making by a patient. That wish for autonomy requires explanations of why a procedure is indicated, a certain medicine given or a period of hospitalization needed. Increased expectations by patients and their simultaneous desire for autonomy have developed during a period of growing skepticism about the idealism and dedication of members of the medical profession.

Consequently, the criteria of behavior of physicians with patients and families as well as with consultants and other medical associates all need closer and more critical scrutiny.

Obviously, it is possible to practice medicine today without having had a formal course in medical ethics, but that doesn't mean one is practicing the best medicine. In the near future, without such training, it will probably mean one is not practicing even good medicine.

The best definition of ethics is that quoted by Bok¹ from the writings of Epicurus: "Ethics deals with things to be sought and things to be avoided, with ways of life and with the telos." (Telos means the chief good, the aim or the end of life.)¹ Thus, medical ethics deals with what is to be sought and what is to be avoided in personal relationships in a medical setting. Is it practical to create a code of rules and regulations? To be explicitly effective, such would have to cover every possible exigency or problem. Would utilitarianism or some type of formalism be the foundation? Creating such a code not only seems impractical with what is known today, but less so with what unknown features may become important tomorrow. This does not mean, however, that general guidelines with broad implications should not be sought and cannot be found having practical effects now and in the future. Each clinical problem is, in a sense, unique but awareness by a physician that one never treats simply a disease, but instead a patient with a disease sensitizes the doctor to the unusual features and their modifying effects

on the planned outline of therapy.

Can one, however, teach ethical guidelines in a meaningful manner? Does such rote modify behavior? In clinical teaching, didactic lectures are supplemented with "bedside" instruction. This allows students to watch the interaction of patient and physician. It is a clinical demonstration. They can witness how the number one member of the entire group, the patient, is questioned and examined by a senior member of the staff. The demonstration of courteous thoughtfulness while applying expertise is more indelible than impersonal didactic recitation.

Unfortunately, time restriction limits such a mode of pedagogy. Perhaps no patient will ask the physician in front of students, "Am I going to be able to resume my work?" or "Do I have cancer?" or "Am I going to die?" The medical-ethical responses to these situations have to be given a lecture-seminar form. One might ask why use "ethical" in considering these questions? The answers to all three questions require value judgment. Physicians and patients may view problems with different attitudes. Physicians responses may range from the evasive to the callous or to the overprotective and paternalistic. Even if patients know what is considered the "best" treatment, they may not choose such for personal and emotional reasons.

How early in the medical curriculum should students be made aware of the multifaceted patient-physician relationship? The answer is before the students' interests can be diverted by some physical or historical diagnostic feature; while their limitation of knowledge, so to speak, forces them to see the patient as a whole. If given the privilege and opportunity of watching a good physician relate to a patient in a clinical setting, one of two types of emphasis can be made: 1) Some interesting diagnostic or therapeutic features stressed or 2) an overall, panoramic view of the patient's problems constructed. In the second approach, the student could be distracted by concentrating on physical signs or laboratory data. Thus, the case evaluation can be accomplished effectively before the student has had clinical training. Both the patient and the physician should be objects of teaching-interest as the latter tries to help the former. Student observations naturally lead to questions such as "what?" is the physician trying to do; "why?" was a certain question asked; "how?" did the physician appear to cope with an unexpected problem related to the patient's future plans, activities, security, etc. It is in the broad spectrum, the total clinical picture, the panorama that the ethical relationships can be found and evaluated. Consequently, medical ethics should be taught early in a medical curriculum; for example, taught before interest in signs of chronic obstructive pulmonary disease obscure the fine points of the multifaceted, supportive, clinical role the physician can have for a respiratory cripple and family.

Bedside teaching in recent years occupies a smaller percentage of medical school curriculum. By the time a student reaches that stage, there is a great desire to see the eye signs of thyrotoxicosis, feel an enlarged spleen or hear a heart murmur. The patient possessing such is valued in proportion to the rarity of the tragic stigma. How coarsening and hardening is that to the physician of the future? Appreciably, judging by the attitude of many medical scientists, teachers and practitioners today and what that attitude has elicited among the public and current so-called "ethicists."^{2,3}

As mentioned, there is an inherent distraction from the ethical issues at the bedside. The immediacy of a clinical problem and technical solution can overshadow the later developments. This has created an atmosphere in some intensive and coronary care units that is dehumanising. While a patient with a tracheal tube has a Swan-Gans catheter placed, various recordings and their significance are discussed across the bed with such remarks as "try" this or that. Exclamations of frustration, failure or success follow with no more consideration than if the patient were an insensate mannequin. As an afterthought, if the patient has submitted passively, a word of encouragement may be voiced. Later, an expression of success is in terms of what the "team" has done, and not what the future holds for the subject.

What can a medical curriculum offer to alter this "supertechician" attitude? There are two steps to be taken. First is to emphasize early in medical training ethical aspects of the very personal patient-physician relationship by carefully-chosen topics and examples in lectures and discussions. Secondly is to give students the privilege of watching wisely-selected senior physicians relate to patients in such settings as their private offices and accompany them to convalescent homes and on hospital rounds. The selection of the preceptor is of utmost importance. Clinical competence alone is not enough. The ethical behavior considered in all of this denotes "caring." Medicines can take care of the disease, but the physician takes care of the patient. It is the latter relationship that a student must witness. The preceptor should serve as a model-image. In so doing, demonstration of a physical sign is not as important as discussing what one does to help the patient with its cause and effect. Some respected members of medical academia and some practitioners cannot qualify for this role. To fulfill it well requires years of personal clinical experience. By "personal" clinical experience, one automatically eliminates those medical demonstrations carried out "through" an associate or postgraduate fellow. Here, a third party has come between the patient and senior physician—reciting history and physical findings as an intermediary. In an academic setting, the so-called "part-time" physician who traditionally works alone with each patient can become a uniquely useful and integral part of teaching. Such an opportunity and privilege to contribute gives this type of preceptor a role of pedagogical importance. What is said and done by the physician and patient are of equal importance to the student. After leaving the presence of the patient, students should be encour-

aged to ask questions as to "why" certain questions were asked and answered as they were. The implications of variations of the answers can be discussed meaningfully; however, to move too far from the patient's actual problems and solutions may lead into a realm of speculation where discussion becomes relatively impractical and unrewarding.

The need described here is the teaching of superior qualities of the patient-physician relationship; the demonstration of thoughtful respect and consideration, requisites of caring. All medical research, prior training, diagnostic studies, therapy and the planning for the future pivot about the Number One person—a human being, requiring assistance, support, guidance and care—the patient.

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Medical Annals of Maryland, 1899-1925

Edited by
L. H. MILES, Managing Editor
Maryland State Medical Journal
1971-74

Nutrition in Maryland, 1899-1928¹

By SAMUEL MORRISON, MD, 1905-

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Great names appear in the nineteenth century as well as in the modern history of nutrition until E. V. McCollum came to Baltimore, the contributions of Marylanders to the field of nutrition were sporadic and only of temporary importance. The Maryland period from 1899 to 1917 stands in marked contrast to the years following 1917. In the former period there were noteworthy contributions. Books were written, and clinical and scientific nutritional articles as well, but there were no fundamental discoveries so characteristic of McCollum and his collaborators.

Elmer Vernon McCollum became Professor of Biochemistry in the School of Hygiene and Public Health of the Johns Hopkins University in 1917. It is interesting that the School was not formally opened until October, 1918, at the old site of the University on North Howard Street and not until the autumn of 1925 was the new building, occupied. Associated with this institution a major part of McCollum's work was done on deficiency diseases, faulty diets and nutrition of animals with isolated and purified food substances. This work, covers the formative and developmental periods of the School of Hygiene and of the Johns Hopkins University.

Perhaps a review of McCollum's book *The Newer Knowledge of Nutrition* will convey to the reader the extent of his work as well as the work of other Marylanders in the period 1899-1925.

The book has gone through four editions, the first in 1918 and the last in 1929. Nina Simmonds, who collaborated with McCollum in so much of his research, became a co-author in the later editions. This book, to a considerable extent, records, summarizes, and interprets experiments that mark the progress of our knowledge of Nutrition.

Before 1900, the idea that there was any marked variation in the quality of proteins from different

sources was not generally appreciated. "It is remarkable," McCollum and Simmonds note, "that students of Nutrition accepted for so long without experimental proof the belief that a chemical analysis revealed the dietary values of foods even though for centuries in several parts of the world restricted diets have produced diseases in man."

McCollum (after 1911) collaborated in some fundamental work which was originally begun in 1906 at the Wisconsin Experimental Station. The object of this experiment was to determine whether rations for cattle so made up as to be alike insofar as could be determined by chemical analysis, but derived each from a single plant, would be of equal nutritive value for growth and maintenance of vigor.

One of the earliest explanations occurring to investigators as to the possible cause for the failure of animals was the probable need for phosphorus in certain organic combinations. A number of experimenters studied, between 1898 and 1909, the relative merits of organic and inorganic forms of phosphorus in Nutrition. McCollum reviewed these studies (1909). In 1907, McCollum took up the study of the cause of the failure of animals to grow on mixtures of purified foodstuffs and employed the rat as the experimental animal. He (1909) introduced a new feature into experiments of this type by seeking to increase the variety of foodstuffs in the diet. This work is deserving of special notice because it reported the first experiments involving growth with a food supply considered to be essentially a mixture of purified foodstuffs, every one of which could be named. Since this diet was something more than it appeared to be, the results were not clearly understood until several years later.

There was no appreciation of the peculiar worth of certain foods as supplements to others until after the year 1900. Nor was there any appreciation of the difference in quality of foods such as we now fully recognize. The astonishing fact that certain lists of common foods do not maintain satisfactory nutrition, even though they have collectively a chemical composition similar to those of another list which is satisfactory for the promotion of nutritive well being, did not become appreciated until about 1915.

In *Nutrition* the studies of McCollum and Simmonds introduced the idea the word "normal" is too indefinite a term. It is less satisfactory than "optimum" to designate the standard of excellence toward which we should strive. They emphasized that our standards of what constitutes normality are based upon common ob-

servation rather than the best possible achievement as illustrated by the best specimens in the population.

In 1913 McCollum and Davis demonstrated the peculiar value of butterfat and egg-yolk fats as contrasted with lard and olive oil. This work led them to the discovery of the special growth-promoting properties of butterfat as contrasted with vegetable fats and certain animal fats.

Between 1913 and 1918, McCollum and his co-workers turned their attention to the study of the deficiencies of our natural foods from the dietary standpoint. It was through the latter studies that the next advance was made in our knowledge of what constitutes a satisfactory diet. Later work by McCollum and Simmonds (1917-1921) demonstrated that the deficiency in mineral elements in wheat and other seeds is limited to the four elements; viz, calcium, phosphorus, sodium, and chlorine.

When a diet consisting of polished rice supplemented with the protein, casein, butterfat, and a properly constituted salt mixture failed to induce growth, McCollum and Davis (1915) found by further experiments that a second dietary essential, of which an animal needs but a very small amount, but which is necessary for growth in the young and for maintenance of health in the adult, could be postulated. This second dietary essential is now known as Vitamin B. As a result of their studies, McCollum and Davis formulated (1915) their working hypothesis of what constitutes an adequate diet. This hypothesis contained all that could be said about the needs of the rat for dietary essentials hitherto unappreciated at this time (1915).

When it was apparent that there were two unidentified dietary factors in the nutrition of the rat, one soluble in fats, the other never associated with fats but easily dissolved out of natural foods by water or dilute alcohol, it became necessary to differentiate between them by names which would characterize them. None of the terms in use seemed desirable, so McCollum and Kennedy (1916) suggested the provisional use of algebraic terms, using a prefix designating characteristic solubility. They proposed the term fat-soluble A and water-soluble B, respectively, to designate them; these terms found widespread acceptance.

The numerous experimental data from the work of McCollum and Simmonds all point to the conclusion that when the life history of the individual is considered, a generous protein ingestion or one allowing a fair margin of safety over the lowest percentage which just suffices to induce maximal growth in the young serves to maintain vigor for the longest possible period.

McCollum, Simmonds, and Pitz (1916) found wheat germ to be exceptionally valuable in several respects and they were the first (1916-1917) to point out the contrast between the state of Nutrition which can be secured with suitable mixtures of leaf and seed, as compared with complex mixtures of seeds.

One of the greatest surprises in the history of nutritional research was the discovery by McCollum, Simmonds, and Pitz of the unique dietary properties of the leaf as compared with those of the other parts of

the plant, especially in the diets of peoples who are largely vegetarian.

McCollum, Simmonds, and Pitz (1916) demonstrated the inability of little rats to grow when nursed by mothers whose diets were deficient either in A or B or both vitamins. They demonstrated that the lactating female cannot put the vitamins into her milk unless they are furnished by her food.

McCollum and Simmonds had repeatedly observed the development of that peculiar form of ophthalmia in animals subjected to faulty diets. They collected numerous observations, all of which pointed to the belief that the eye disease in question was noninfectious and that it could more satisfactorily be explained on the basis of specific starvation for vitamin A than on any other. They (1917) correlated these observations on rats with those reported by Bloch and by Mori and concluded that the xerophthalmia or keratomalacia produced experimentally in animals is the analogue of the condition reported in man. On this evidence they formulated the view that this type of xerophthalmia is a manifestation of a deficiency disease due specifically to lack of vitamin A.

McCollum and Davis (1915) in their study of the wheat kernel first called attention to the fact that the germ was rich in the substance curative for polyneuritis. They suggested that it was the loss of the germ rather than of the cortical layer which deprived rice of its protective power in beriberi.

Voegtlin and Myers (1919) called attention to the fact that vitamin B reacted to chemical reagents such as methyl alcohol, silver, lead, and barium salts in a similar way to secretin. Souza and McCollum (1920) attempted to use yeast cell multiplication as a test for vitamin B and showed that no confidence could be placed in it, since yeast grows slowly in a vitamin-free medium.

Shipley, McCollum, and Simmonds (1921) found the bones of rats in polyneuritis brought on by a diet adequate except for lack of vitamin B and G to be quite indistinguishable from those of guinea pigs dying of scurvy.

Parsons (1920) produced acute scurvy in guinea pigs. She then fed the fresh livers of rats reared on a diet free from vitamin C to the scorbutic guinea pigs and observed prompt cure. The rats were able to synthesize vitamin C.

Parsons in collaboration with McCollum (1920), Hutton (1924), and Reynolds (1924) extended these studies on vitamin C. McCollum and Pitz did not at first accept the view that scurvy is a deficiency disease.

In 1917, while carrying out a series of experiments designed to discover the nature of the dietary deficiencies of two or more cereal grains, McCollum and Simmonds observed that many of their rats developed beaded ribs and showed collapsed thoraces. A systematic effort was made during the next two years to find what kinds of inorganic salt additions would supplement these cereal diets in order to prevent the abnormalities of the skeleton. It was found that no matter

what salts were added, a normal skeleton was not produced unless a calcium salt was included in the diet. It was recognized that, although these abnormalities suggested rickets, a diagnosis of rickets could not be made from gross bone lesions, but a histo-pathological study was necessary.

In 1919, the late Dr. John Howland was shown some of these animals. He believed some of these bone conditions were rickets. This interview resulted in a co-operative investigation between the Department of Pediatrics and the Department of Chemical Hygiene, Doctor E. A. Park and Doctor P. G. Shipley representing the former, and the authors (McCollum and Simmonds) the latter.

Park and Howland (1921) proved by means of the X-ray that the administration of cod liver oil to rachitic children was followed by the deposition of lime salts in the cartilage and bones after a period of 15 to 21 days. Shipley and co-workers (1921) pointed out that when cod liver oil was administered to animals with rickets a line of calcium phosphate was laid down in the matrix of the proliferative zone. They also pointed out (1921) that the changes produced by sunlight in the skeleton of rats with experimental rickets did not differ in any important respect from the changes produced when animals are kept in room light but on a diet supplemented by cod liver oil. Years later (1926) Macht and Stepp studied the effect of polarized light on experimental avitaminosis.

Shipley and co-workers (1921) reported the production of rickets by means of two diets. This observation of Shipley and co-workers, as well as that of Sherman and Pappenheimer, marked a distinct advance in the investigation of rickets. They showed the importance of the inorganic constituents of the diet, especially of phosphorus in relation to the disease.

McCollum and co-workers (1921) studied the effect on growing rats of diets deficient in calcium. Shipley and co-workers (1921) stated, "whatever the defects in the salt composition in the diets, employed, the effect of the addition of cod liver oil was greatly to improve the growth and condition of the animal as a whole, and to shift the pathological condition in the bones toward the normal condition." Park, Guy, and Powers (1923) and Park (1924) extended the studies on the effect of cod liver oil in animals fed varying ratios of calcium and phosphorus.

Shipley and co-workers (1921) reported the production of rickets by means of a diet relatively high in calcium, and very low in vitamin A and phosphorus. The calcium was high only in the sense that it was excessive in proportion to the phosphorus content, which was extremely low. These and other experiments (1922) led them to an appreciation of the significance of the quantitative relationships between calcium and phosphorus in the diet. They were led to believe that there are two kinds of rickets: one is characterized by a normal or nearly normal blood calcium and a low blood phosphorus (low-phosphorus rickets; calcium:phosphorus ratio large); the other, by a normal or nearly normal blood phosphorus but a low blood calcium (low-calcium rickets; low calcium:phosphorus

ratio). The investigations of Howland and Kramer (1921) and of Kramer, Tisdall, and Howland (1921) on the calcium and phosphorus content of the blood serum in rickets and tetany supported this view.

Shipley and co-workers (1921) discussed the relative effectiveness of cod liver oil and butterfat for protecting the rat against an insufficiency of calcium in the presence of what under normal conditions is about a normal phosphorus supply. They were not willing at that time to make the statement that a separate factor distinct from vitamin A was to be found in cod liver oil. They stated: "We have not found it possible to demonstrate experimentally a difference between the effects of cod liver oil and butterfat when the content of the diet in calcium and phosphorus is near the optimum, the other elements in the diet being satisfactory." They further stated: "These results suggest the possibility that a dietary essential distinct from the anti-ophthalmia substance (vitamin A) may exist. If this is the case, this would appear to be present in butterfat in small amounts but to be very abundant in cod liver oil." In 1922, McCollum and co-workers presented evidence which was all but conclusive that there is in cod liver oil and butterfat a calcium depositing substance distinct from vitamin A.

McCollum and co-workers demonstrated that Diet 3143 always produces a florid rickets and that these animals can be used to determine the presence or absence of vitamin D in foodstuffs. In 1922 they demonstrated that animals in this condition will produce a positive "line test" if allowed to starve. Howland and Kramer (1922) showed this calcification to be accompanied by changes in the calcium and phosphorus in the serum. Park, in 1923, gave his reasons for regarding the rickets produced in rats to be identical with that seen in human beings.

Shipley (1924) made the fundamental observation that a bone from a rachitic rat begins to calcify within 48 hours when placed in the serum and plasma of a normal rat or of a rachitic rat during the healing process. Shipley, Kramer, and Howland (1926) carried these studies further.

Howland and Marriott (1918) discussed the theories concerning the etiology of infantile tetany. They stated that the evidence in 1918 failed to support most of the theories, although there had been in the literature for 100 years satisfactory descriptions of infantile tetany. Kramer, Casparis, and Howland (1922) treated five children showing clinical evidences of rickets, confirmed by X-ray examination of the bones, by systematic exposure to the rays of a mercury quartz lamp. This was followed in every case by a healing of the rachitic process in the bones. The changes in the phosphorus of the serum following the light treatment were the same as when the children were given cod liver oil. The pigmented skin of Negroes did not interfere with the action of the light rays.

Howland and Kramer (1922-1923) found that in uncomplicated rickets the concentration of calcium in the serum is normal or nearly so, whereas the phos-

phorus concentration is low, so that the product of the two concentrations is at or below 30. They pointed out how significant the products of these concentrations are.

McCollum and Davis (1915), in a study devoted to the effect of the composition and amount of the mineral content of the diet on growth and reproduction, employed a diet which led to surprising results in that all the lots failed to repeat reproduction at normal intervals. They concluded: "This failure is certainly the result of some factor other than the character of the mineral content and must remain unexplained for the present." This antedated the remarkable work of Evans and Bishop (1922) on vitamin E.

When Goldberger undertook the prevention of pellagra in institutions by improving the dietary little was known of the properties of the different natural food-stuffs which subsequently have become known through the systematic studies of individual foods by means of the biological method of analysis introduced by McCollum and Davis (1915).

Voegtlin (1920) tested on over 100 pellagrous patients the effects of two types of diets on the clinical condition of the disease. Voegtlin and Harris (1920) reported pellagra in infants who were nursed by pellagrous mothers, and cited older literature which shows that a considerable number of cases of pellagra have been observed in infants.

Whipple and Robschey-Robbins and their co-workers (1925-1928) studied the effects of different food-stuffs on blood regeneration in normal dogs made anemic by repeated bleeding. As early as 1920 Whipple and Robschey-Robbins found kidney essentially the equal of liver in blood regeneration.

In order to discover whether the mammary gland could synthesize vitamins A and B, McCollum and Simmonds (1916-1918) carried out a series of experiments with lactating rats whose diets were faulty in known respects. The results showed conclusively that vitamins A and B pass into the mother's milk only when they are present in the diet of the mother.

The chapter on the pregnant and nursing mother strikes the keynote of this book. It affords proof of the existence of, and points the way to the remedy for one of the greatest sources of human inefficiency and suffering. It almost dramatically leads up to what is a fundamental fact: that the nursing mother cannot, except in a very limited degree, put into her milk from her bodily reserves that which she does not receive in her food supply. McCollum also stressed the need for care in the management of maternal and infant diets in combatting the deplorable condition of teeth in America.

Lange and Simmonds (1923) noted no significant difference in the reaction to infection of rats infected with bovine tubercle bacilli by subcutaneous inoculation on diets of varying protein content either in the general condition, weight curves, or in the gross or microscopic autopsy findings. Lange (1925) continued the study of the effect of deficient diets on the susceptibility of the rat to experimental bovine tuberculosis.

In 1919, McCollum, Parsons, and Kalmbach sought and found the opportunity to test on human beings to what extent the principles established in animal experiments apply to the nutrition of children. They were able to demonstrate the validity of the view that a dietary selected from cereals, tubers, fleshy roots, and meat does not prove satisfactory for the physical development of young children. It showed further that milk is an effective supplementary food for such a type of diet; this has been repeatedly shown to be the case with animals.

McCollum and Simmonds have repeatedly emphasized an inter-relationship between the quality of the food supply and the span of life of experimental rats, and have pointed out that, with our present knowledge, it is easily possible to make the span of life of this species anything that is desired up to perhaps 40 months.

In the bibliography the names referred to which are of interest in this article are Adams, McCollum, Abel, Bailey, Hyde, Davis, Whipple, Estill, Hart, Fuller, Howland, Kramer, Boone, Casparis, Shelling, Shear, Orent, Tisdall, Kruse, Davis, Drescher, Halpin, Hoagland, Kennedy, Parsons, Pitz, Rask, Becker, Simmonds, Shipley, Kinney, Grieves, Park, Guy, Powers, Polvogt, Holt, Voegtlin, Myers, Harries, Neill, and Hunter. Most of these names represent investigators who worked with McCollum—some before he came to Maryland, others after. Some of the names are those of individuals who had some connection with Maryland although some of their work was not done here.

The work summarized and paraphrased here gives only a part of the research with which the names of McCollum and his co-workers are connected. A mere list of the papers written by this group of investigators would fill more space than is allotted for the subject. Moreover, to list all the men who have contributed to nutritional research and to give a few details of their works would likewise require too much space. However, this information can easily be obtained by reference to *Men of Science*. A few of the names taken at random may be referred to only as examples of what could be done were there available space.

Dr. J. J. Abel, Hopkins, 1883-1884; Pharmacol. Hopkins, 1893- ; Editor, *Jour. Pharm. and Exp. Therap.* Work: Composition of animal tissues and fluid; function and isolation of special chemical principles of animal organisms; pharmacological action of alcohols, active principles of the pituitary gland; histamine and like substances in animal tissues and hydrolytic products; isolation of the pancreatic hormones; chemical and biological properties of insulin in crystalline form.

Dr. J. C. Hemmeter, Prof. Physiology, Sch. Med., Maryland, 1891-1909, Clinical Professor Diseases of the Stomach, Coll. of P. & S. Baltimore. Work: Physiological at this time was Clinical Professor of Diseases of the Stomach, Col. of P. & S. Baltimore. Work: Physiology and pathology of the digestive organs; physiological foundation of piano technique; history of physiology and medicine; diseases of the intestines.

Dr. B. Kramer, Inst. Pediat., Hopkins, 1917-1920; Assoc. Prof., 1920-1922; Assoc. Pediatrician, Hopkins Hosp., 1923-1924. Work: Inorganic components of blood; rickets; calcification.

Dr. W. S. McCann, Assoc. Prof., Hopkins, 1921-1924; Assoc. Physician, Hopkins, 1921-1924. Work: Disorders of metabolism.

Dr. E. L. Opie, A. B., Hopkins 1893; M. D., 1897; Asst. Bacter., Hopkins, 1899-1900; Instr., 1900-1901; Assoc., 1901-1904. Work: Histology and pathology of the pancreas and its relation to diabetes mellitus; diet in relation to certain toxic substances; protozoan micro-organism related to the malarial parasites; eosinophile leucocytes; necrosis and cirrhosis of the liver; enzymes and anti-enzymes of inflammatory exudates; pneumonia and influenza; immunity, tuberculosis.

Dr. E. A. Park, Johns Hopkins, Baltimore; Medicine, Pediatrics, AB, Yale, 1900; MD, Columbia, 1905; Instr. Path., Columbia, 1909-1911; Assoc. Prof. Pediat., Hopkins, 1914-1921; Prof., Yale, 1921-1927; Sch. Med., Hopkins, 1927-. Work: Rickets.

Dr. L. G. Rowntree, Asst. Med., Hopkins, 1907-1908; Instr. Pharmacol., 1908-1910; Assoc. Exp. Therapeut., 1910-1913; Assoc. Prof. 1913-1914; Med., 1914-1916. Work on water balance, water intoxication, vivi-diffusion.

Dr. John Ruhräh, MD, Col. P. & S., Baltimore, 1894; Prof. Diseases of Children, Maryland. Work: Medical history, nutrition, dietetics and introduced soybean into infant feeding.

Dr. Carl Voegtlin was Assistant Med., Hopkins 1904-1905; Assoc. Prof. Pharmacol., 1906-1913. He worked on metabolism, function of the parathyroid, calcium treatment of tetany, dietary theory of pellagra, vitamins and deficiency diseases, biochemistry of cancer.

Dr. G. H. Whipple, MD, Johns Hopkins, 1905; Asst. Path., Hopkins, 1905-1906; Instr. 1906-1907; Res. Pathologist, 1908-1914; Assoc. Path., 1908-1910. Work: Pigment metabolism, pancreatic lesions, and hemoglobin formation in anemia.

If one examines outstanding books or treatises one will very likely be rewarded by names of men who made noteworthy contributions to the subject of Nutrition. For that reason the writer has resorted to this method. Again only a few examples may be given owing to lack of space.

Among the contributors to Abt's System of Pediatrics are the following Marylanders: J. Howland, J. H. Mason Knox, Jr., Dean Lewis, J. Ruhräh, F. H. Garrison (on the history of Pediatrics), R. A. Bolt (former lecturer at Hopkins), W. C. Davison, and L. B. Hohman. The subjects are not entirely on Nutrition but they are on various phases of pediatrics. The system is composed of eight volumes, copyright 1923-1926, W. B. Saunders Co. Its editor, I. A. Abt, is a graduate of J. H. U., 1889. He is also author of *The Baby's Food* (1917) and the editor of pediatric volumes in the Practical Medicine Series (1906-1921).

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In his *Introduction to the History of Medicine*, F. H. Garrison refers to Howland's studies of metabolism in

infancy; to the work of McCollum, Davis, and Kennedy (1913-1916) on vitamins A and B; to the production in rats of experimental rickets by dietetic deficiency by McCollum and Simmonds (1917); and to Howland and Park's (1920) X-ray check of the cod liver oil treatment of rickets. The studies of E. L. Opie (1901) and W. G. MacCallum (1909) on the pancreas are mentioned as well as Halsted's (1906) and MacCallum's and Voegtlin's work on tetany.

Harvey Cushing's (and associates at Hopkins) remarkable work on the pituitary is discussed in detail (1908, 1912, 1913). Then, as a surprise, there is this mention: "The most important advance made by chemical investigation in the early period was in the physiology of digestion. The first work in this field, in order of time, was the graduating thesis of John R. Young, of Maryland '*An Experimental Inquiry into the Principles of Nutrition and the Digestive Process*' (Philadelphia, 1803)." Others mentioned include: L. F. Barker for, among other things, his work as editor of a systematic work on Endocrinology and Nutrition and J. C. Hemmeter, a pioneer in radiography of the stomach (1896) and duodenal intubation and author of the earliest complete American treatises on diseases of the digestive organs (1896), stomach (1897), and the intestines (1901), and a manual of physiology (1913).

In McLester's book on *Nutrition and Diet in Health and Disease*, many references are made to Marylanders. As one would expect, McCollum and his co-workers are referred to extensively; other names appear among which Marshall, Keefer, Perlzweig, McCann, Longcope, Barker, and Sprunt may be mentioned.

Although published in 1928 by the Chemical Foundation, the book *Chemistry in Medicine* is reviewed here because it represents a cooperative treatise intended to give examples of progress made in medicine with the aid of chemistry before that date. In this book, Chapter 2 on *Heredity and Development* is written by Alexander Weinstein, Ph.D., who has been associated with the work in Zoology at the Johns Hopkins University. Chapter 4 on *The Story of the Discovery of the Vitamins* is written by E. V. McCollum, Ph.D., Sc.D. and Nina Simmonds, Sc.D. In this brief resumé is recorded a most interesting development to which the authors contributed a major share. Chapter 5 begins a series of articles under the heading *The Conquest of Dietary Diseases*; Article 1 *No Child Need Have Rickets* is written by James M. Gamble, MD, who was associated at the Johns Hopkins Medical School (1915-1922) with the late Dr. John Howland. In this article there is recorded the discovery by Howland and Kramer in this country and, independently, Iversen and Lenstrup in Denmark, that the concentration of phosphate ion in the blood plasma is greatly lowered in rickets. Article 2 entitled *The Hormones of the Suprarenal Glands* is a part of the general heading of Chapter 6; "Chemical Regulators of the Body"; John J. Abel, MD and E. M. K. Geiling, Ph.D., MD are the authors.

Doctor Abel is our most famous American in the field of study of the chemistry of life. Associated first with the University of Michigan as a Professor in its

Medical School (1891-1893), his life work has been done almost exclusively at Johns Hopkins University (1893 to the present writing). Article 4 of Chapter 6 is entitled *The Hormones of the Pituitary Secretions* and is written by E. M. K. Geiling, Associate Professor of Pharmacology, J. H. M. S., since 1921 an associate of Abel. Chapter 8, *The Alleviation of Suffering*, has its first article *Chemistry in Medical Diagnosis*, written by Leonard G. Rowntree, MD, who found an opportunity for his active interest in medical research in the Johns Hopkins Medical School (1907-1916). Article 6 of Chapter 8 is entitled *Chemistry and High Blood Pressure* and is written by Ralph H. Major, MD, who studied at Johns Hopkins. Other articles are written by John W. Churchman, MD, who was associated with the Johns Hopkins Medical School as Instructor in Surgery and the Johns Hopkins Hospital as Resident Surgeon and by Carl Vogtlin, MD, who was associated with the Johns Hopkins Medical School in the Department of Pharmacology from 1904-1913.

In Graham Lusk's *Elements of the Science of Nutrition*, W. H. Howell's work (1906) is recorded as having first indicated the absorption of amino-acids by the blood and the first actual isolation of amino-acid from blood was reported by Abel, Rowntree, and Turner (1913-1914). Again, the remarkable work of McCollum and Hoagland (1913-1914) on protein metabolism is discussed. Attention is directed to the description by McCollum, Simmonds, Shipley, and Park (1922) of the "line-test" procedure, a delicate biological test for calcium-depositing substances. Park and Howland (1921) are accredited with their original demonstration by means of X-ray observations that cod liver oil was administered to children with rickets when curative results were discernible in two or three weeks. Again space is not available to describe other original researches by Kramer, Howland (Ca determination, infantile tetany), to the work of Boggs and Morris (1909) (blood fat in experimental anemia), to the work of Mosenthal and Lewis (1917) in Janeway's Baltimore Clinic described as "one of the most interesting researches upon diabetes ever accomplished," and to the extensive studies of Jones and his school (Buell, Perkins, Amberg, Richards, Partridge, Austrian) on nucleic acids.

In their book *Diet in Health and Disease* Julius Friedenwald and John Ruhräh have endeavored to give a reasonably concise account of different kinds of foods, their composition and uses, and also to set forth the principles of diet both in health and disease. This book represents a wealth of experience having gone through six editions, the last in 1926, the first in 1904.

In it references are made to McCollum, Boggs (estimation of protein, a test for which is suggested-Bull. J. H. H. Oct. 1906); Dr. Manuel Gichner (for revision of a large part of the article on Diabetes); Rowntree, (water intoxication-Arch. Int. Med. XXXII, 157, August 1923); Holt and Howland, Osler (Tuberculosis and importance of diet); and McCann. A series of experiments is recorded which were performed by the authors

in the Pathologic laboratory of the Johns Hopkins Hospital, Baltimore, in which actual cirrhotic changes in the liver were induced by the administration of alcohol. Reference is also made to Welch (*The Physiologic Aspects of the Liquor Question*); Barker and Sprunt (Addison-Biermer type of pernicious anemia); Mosenthal (various test diets devised for testing renal function); Howland and Marriott (Treatment of acidosis); Halsted and Finney (under heading Diet and Laparatomies); and to Cushing and Livingood (J. H. H. Reports - Vol. IX in reference to Stomach and Small Intestine). The book gives a remarkably complete set of hospital dietaries for diseases, individuals, institutions, etc. It includes a section on recipes and devotes sections to *Cuts of Meat*, *Rapid Reference Diet-Lists*, and *War Dieting*. The book is the acme of completeness and even includes a chapter on *Army and Navy Rations*.

Dietetics for Nurses by Julius Friedenwald and John Ruhräh has gone through five editions, the last in 1924, the first in 1905. In the preface the authors write that "the aim of this book is to give the essentials of dietetics." Its table of contents shows that it follows the larger book on *Diet in Health and Disease*. It is simplified for nurses' classes.

Julius Friedenwald and John Ruhräh jointly made some observations on the effect of certain diet cures in diabetes mellitus in 1905, and again in 1910 they investigated the use of the Soybean as a food in diabetes.

In 1924-1925, a series of lectures was given at the Mayo Foundation and a number of universities. These were published in book form by W. B. Saunders Co., 1925. Pages 137 to 208 are devoted to *Our Present Knowledge of Vitamins* by E. V. McCollum. Throughout the volume, names of Marylanders are mentioned. McCollum and Simmonds (1925) published a small book entitled *Food, Nutrition, and Health*, written for the general public. A *Special Insulin Number* (1922) of the *Journal of Metabolic Research* again refers to a number of Marylanders among whom are L. F. Barker, Julius Friedenwald, D. R. Hooker, W. H. Howell, E. V. McCollum, E. K. Marshall, L. H. Weed, and M. C. Winternitz.

In Osler's *Principles of Practice of Medicine*, McCrae (10th edition, 1927, 1st ed. 1892), Section 4 is devoted to Deficiency Diseases and Section 5 to Diseases of Metabolism. In the discussion of gout some important work by Fitcher is mentioned and under Haemocromatosis, mention is made of Sprunt's admirable paper on this subject which appeared in the *Arch. Int. Med.* July 1911.

In *Diseases of Infancy and Childhood* by Holt and Howland (Ninth edition 1927, first edition, 1897) it is noted that the editions since 1911 represent more and more the revising and rewriting ability of Dr. Howland. Other names connected with this edition are Wilburt C. Davison and E. A. Park. Section 2 of the book is devoted to Nutrition. Vitamins are discussed on Page 112. Under Rickets on Page 188, the names of McCollum, Park, and their associates are mentioned. On page 205, Kramer's name is mentioned. Section 3 is devoted

to *Diseases of the Digestive System*. Park and Holt are referred to on Page 278, Flexner on Page 295 (dysentery in children in Baltimore). Celiac disease is discussed on Page 308 and Howland's name should be mentioned in this connection (personal communication, E. A. Park).

J. Whitridge Williams' *Obstetrics* (5th Edition 1926, 1st in 1903), discusses metabolism at the time of labor, general metabolism in pregnancy, and in eclampsia. Diet during pregnancy and puerperium are also discussed.

The author had originally intended to list certain noteworthy references as they appear in the Surgeon General's Index Catalog (1886-1906 and 1906-1925), in the libraries of Baltimore (Welch and Medical Chirurgical) and in the Quarterly Cumulative Index, but space is not available. By glancing through these references one can almost read the story of Nutrition in Maryland. It was also intended to list the various nutritional journals not only because many of them are printed in Baltimore, but because members of their editorial staffs and many of their contributions have come from Maryland.

In closing, one may write that probably no one more than McCollum has shown us what constitutes an adequate diet, and how the physiologic processes are perverted when errors of diet exert their effects. He has pointed out the "Protective Foods," and he initiated those cooperative studies on rickets which demonstrated the existence of a fourth vitamin. With such a beginning there is no reason to doubt that many remarkable discoveries still await the nutrition investigator. □



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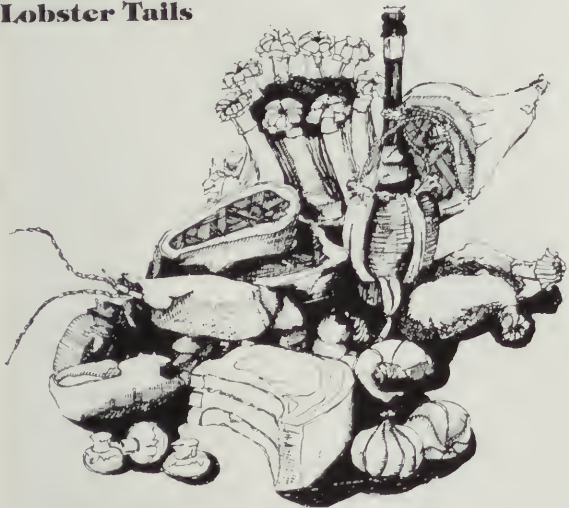


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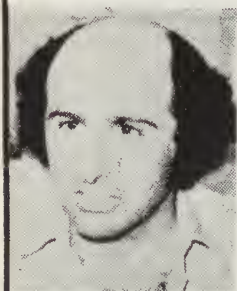
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Non-Ossifying Fibroma

By MARK C. VACCARO, MD

Dr. Vaccaro is affiliated with the Department of Radiology of the University of Maryland Hospital, Baltimore, MD 21201, where he can be contacted for reprint and other data.

Case History

A 16-year-old black male presented to the emergency room with pain in his distal right leg and ankle following a football injury at school. Physical exam revealed several ecchymotic areas over his anterior lower leg, but there was no tenderness to palpation or limitation of motion. Radiographs of the distal tibia and ankle were obtained (Figures 1 and 2).

1. What is your diagnosis?
2. What entities should be considered in the differential diagnosis?

entail diagnosis?

3. Should a biopsy be performed?

4. What is the natural course of this lesion and what is its clinical management?

Answers on next page.

DOCTORS IN THE NEWS:

Johns Hopkins physician **Carol Johnson Johns, MD** has been named Acting President of Wellesley College in Massachusetts effective Sept. 1, 1979. A member of the College's Class of 1944, Dr. Johns has been a member of its Board of Trustees since 1971, currently serves on the Board's Executive Committee and has been Trustee Chairman of the Wellesley National Development Fund Committee. Associate Professor of Medicine at the Hopkins School of Medicine, where she received her MD in 1950, the Med-Chi Councillor is an internationally-known expert in chest disease. She is a member of the Baltimore City Medical Society and the Maryland and American Thoracic Societies, too. □



Figure 1: AP view of the lesion in the tibia of a 16-year-old male.



Figure 2: Lateral view.

Radiological Case of the Month

Case history on preceding page.

Discussion

The diagnosis is non-ossifying fibroma, unrelated to the patient's acute trauma.

Non-ossifying fibromas are frequently discovered incidentally in children and young adults when an extremity is examined radiographically for another reason such as trauma. These benign lesions often have such a characteristic radiographic appearance that biopsy is usually not warranted. This entity commonly affects the cortical metaphyseal regions of long bones of the lower extremities, although short bones and bones of the upper extremity may be involved. The lesion is primarily radiolucent, two-seven cms. in size, and is oval in shape with a scalloped margin. This margin is narrow, clearly-defined and sclerotic. The overlying cortex is thinned and expanded, but does not show a periosteal reaction unless a pathologic fracture has occurred. Early lesions are eccentric in location within the metaphysis; however, as they grow, they may fill the entire thickness of the bone. The occurrence of a non-ossifying fibroma encompassing the entire thickness of a bone is more commonly-seen in the slender bones such as the fibula or ulna rather than in the larger bones. As was the situation with this patient, the lesion may have a multilocular appearance.

Non-ossifying fibromas are almost always solitary; however, they can rarely be multiple. These lesions are found incidentally in individuals between eight and 20 years of age, and they are almost always asymptomatic. Surgery may be performed for pain or a pathologic fracture.

Local excision is the procedure of choice for small lesions, whereas surgical curettage and bone grafting may be necessary for the larger lesions.

Although the radiographic appearance of non-ossifying fibromas is almost pathognomonic, a few entities might be considered in a differential diagnosis. Monostotic fibrous dysplasia may have a similar appearance; however, the lesion in fibrous dysplasia is more centrally-located in the metaphysis and is less radiolucent. Non-ossifying fibromas may have a few apparent loculations, but the lesion of fibrous dysplasia may have many, at times giving it a "soap bubble" appearance. A unicameral bone cyst could be considered; however, the eccentric location of the non-ossifying fibroma and its frequent lower extremity location should be helpful in making the distinction.

When non-ossifying fibromas are examined pathologically, they have a reddish-brown to yellow appearance and vary from soft to firm in consistency. Histologically, these lesions are composed of connective tissue of varying cellularity. In the heavily-cellular areas of the tumor, spindle-shaped fibroblasts and multinucleate giant cells are found. Since this type of tissue is rather vascular, red blood cells and hemosiderin pigment can be found, which give the tumor its reddish-brown appearance. Other tissue within the

lesion contains lipid-laden macrophages, which account for the yellowish color.

The relationship of the non-ossifying fibroma to the very frequent benign fibrous cortical defect is still somewhat controversial. The question arises as to whether these two lesions are separate entities or whether they are manifestations of one disease process presenting at different stages of development. The benign fibrous cortical defect is a rather small metaphyseal focus of tissue which radiographically has a lytic appearance involving the bony cortex. A large percentage of normal children show one or more benign fibrous cortical defects, averaging one-two cms. in size. These lesions have a peak incidence between ages four-eight years, and they spontaneously regress. Histologically, these cortical defects are identical to non-ossifying fibromas, and because of this finding, many individuals prefer to place both the benign fibrous cortical defect and the non-ossifying fibroma under a single category such as fibrous metaphyseal defects or fibroxanthomas.

Most benign fibrous cortical defects regress and heal spontaneously. Some investigators, however, believe that a small percentage of these cortical defects do not heal but, rather, continue to enlarge to become non-ossifying fibromas. Most non-ossifying fibromas are then believed to heal spontaneously, as do the benign fibrous cortical defects, as it is rare to find a non-ossifying fibroma in an older adult. The spontaneous healing of non-ossifying fibromas as documented by serial radiographs has been presented in the literature. The process may take several years, during which the defect becomes less and less defined. The former site of the lesion may remain as a sclerotic zone of bone or the site may have a completely normal appearance.

In summary, non-ossifying fibromas are benign metaphyseal lesions of children and young adults. These lesions are often so characteristic radiographically that biopsy is usually not warranted. Although most of these lesions are clinically silent and regress spontaneously, some require surgical intervention for pain or pathologic fracture. Non-ossifying fibromas and benign fibrous cortical defects are biologically and histologically identical and frequently thought of as manifestations of a single entity.

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DOCTORS TAKE NOTE:

Oct. 19-20, Crit. Issues in Health Law, Sheraton Wash. Hotel, Wash., DC, sponsored by Amer. Soc. of Law and Med. For details, call Lee J. Dunn, Jr., Esq. at (312) 649-2900.

A 200-Year-Old Book of Patient Records

Suppose that some of your patient records somehow survive the next 200 years and are found among the papers of your great-great-great-grandchild. In a time when man may manipulate body tissues in a laboratory to grow hearts, kidneys and other organs for surgical replacement of diseased and worn-out parts; when cancer, the cardiovascular diseases and others have been eliminated and have been replaced by conditions that we consider obscure, or are totally ignorant of, as the number one, number two, etc., killers of that future time, what would be the reaction of a physician studying your notes? Can you imagine someone dismayed at the barbaric idea of implanting a nuclear-powered, mechanical device inside the body to regulate heartbeat? Think of the medical instructor who looks at your charts and then refers to the crudeness of transplanting a kidney from a cadaver, or even a *live* donor, to the body of a patient with kidney disease? The columnists and popularizers of medicine 200 years from now, after examining your records, may discuss the ineptness of the physicians of our prescientific time who were helpless in the face of cancer.

I say all this as an introduction because I have in front of me a manuscript book of approximately 90 pages, entitled *Medical Cases as They Occurred in Harford County, Taken by John Archer, Jr., MD*. The manuscript came to light about three months ago as part of the estate of Dr. Archer's great-grand-great-grandchild and was acquired by the Faculty just a few days ago. The manuscript describes the significant cases seen and treated by Dr. Archer between the years 1792-1805. He was the son of the first physician to obtain a Medical Degree from an American medical school, and he studied first under his father at Medical Hall in Harford County, MD. Later, he received his MD degree from the University of Pennsylvania, where he studied under Benjamin Rush. The variety of cases described in this young medical graduate's notebook illustrate American medicine at its best, during the period immediately following the American Revolution. Given the rapid advance of medical knowledge today, it is likely that medicine even 100 years from now will be far more advanced from that of the present day than present-day medicine is advanced over what is described in this notebook. This fact should lead us to humbly approach this picture of medicine 200 years ago as an illustration of how much we have to learn, rather than of how far we have come.

At the bottom of his title page, Dr. Archer wrote the following quote from his teacher, Benjamin Rush: "Record all facts and extraordinary occurrences in the practice of medicine." Thus, the theme was set for the new physician's notebook.

The title page is followed by a six-page list of prescriptions; these describe the recipes for various ointments, tonics and pills that were the primary therapeutic tools of the American physician of the time. The recipe for mercurial ointment instructs the physician to put crude mercury into a brazen mortar, melt a small piece of rosin in a ladle and add turpentine until the mixture is about the consistency of honey, cool the mixture and pour it on the mercury, stirring it until it is entirely "killed." This ointment was used to treat a variety of diseases including syphilis and various skin diseases such as cancer.

Another recipe, for Extract of *Cicuta*, states that hemlock is to be gathered when the flowers begin to fade. The herb is to be bruised, the juice expressed and then boiled gently until two-thirds is wasted. The pulp is then formed into balls, spread on a marble plank and dried to a proper consistence for pills. The recipe concludes with a note, "Apparent effects—giddiness of the head—motions of the eyes as if something pushed them outward. Dose—gradually to be increased, but should it occasion spasmodic twitchings, heat and thirst, the use of it must be forbidden."

The list of prescriptions is followed by a five-page list of preferred treatments for specific diseases, all quoted from physicians associated with the University of Pennsylvania. Dr. Wistar is cited as the source of an alum prescription to be used for diabetes, a recipe using flour, yeast and finely-powdered charcoal to form a poultice to treat gangrene, and also as stating "The bladder should always be punctured above the pubic when necessary to draw urine by puncture." For ascites, Dr. Archer copied Benjamin Rush's prescription for juniper berries mixed with wine, of which a wineglass full is to be taken three times a day.

Next follows a four-page section entitled *Virtues of Trees*. The bark, roots and leaves of various trees are listed according to their astringent, tonic or diuretic effects. We learn that an extract of ash bark was used to treat snake bites, a paste of ground laurel leaves was applied to corns, tea made from nettle leaves was used to treat amenorrhea, a tincture formed from cayenne was used as a wash for treating rheumatism and dried skunk root in doses of 10 grams, three times a day, was recommended for pulmonary phthisis.

Smallpox was probably the major medical problem in the American colonies. In 1792, when Dr. Archer began practice, Jenner's research on vaccination was still six years from publication, and inoculation was the accepted prophylactic measure against smallpox. Following his list of prescriptions and standard cures, Dr. Archer has a seven-page section on inoculation, pointing out that

"Infection may be used out of the mature pock or prepared. Infection is prepared by wetting the thread in fresh variolus matter and drying it gradually before the fire and keeping it in a vial for use. Inoculation is carried out by an incision to be made in a fleshy part of the arm or leg . . . not more than thro the cuticle to the cutis, so as hardly to draw blood and no more. If matter just out of the pock is used, dip the point of the lancet in the matter and rub it on the incision until dry— If prepared infection is used, cut the thread . . . about the eighth or tenth of an inch in length, then wet the point of your lancet in water which applied to the thread you cut off and when it is moistened, apply it to the incision and rub it on until you get some of the dissolve matter in the incision, then expose it to the dry air . . . The second or third day, open the incision . . . and apply of the fresh or prepared matter as before. Nothing more is to be done respecting the operation. If the infection has taken place, about the fifth day the part will be a little raised and inflamed."

Dr. Archer recommended giving two purges: one on the fifth day after inoculation, and the other on the occasion of the fever to prepare the patient for a mild form of smallpox. He also recommended that small quantities of mercury be given every night to assist the purges. The eruptions on the inoculated patient would last from about the eighth day until the 15th day; during this period, the patient was encouraged to go into the open air and to use moderate exercise. If the patient felt obliged to go to bed, he was to get up frequently and go into the open air. Dr. Archer reports that in the winter of 1795, there were 500-600 persons inoculated for the smallpox. His notes go to great lengths to describe complications among those inoculated and the procedures used to treat them, but he does not mention any fatalities.

The next 40 pages of the manuscript describe individual cases of 17 diseases treated by Dr. Archer: a carious ulcer in the nose, phthisis pulmonalis, cutaneous eruption, nitre taken into the stomach, epilepsy, amenorrhoea (sic), pendulous abdomen, poisoned feet, tinea capitis, dysentery, chronic dysentery, spirit taken into the stomach, copper taken into the stomach, afterpains, dropsy, herpes, scarlatina anginosa and stone in the bladder.

In describing each case, Dr. Archer seemed to follow a standard format. First, there is a paragraph written in the third person, naming the patient, specifying the date that the patient made application to Dr. Archer for a particular problem and stating the duration of the problem. If the patient had consulted other physicians, this is also noted. This paragraph usually ends with the words: "The doctor directed as follows—" One or more prescriptions follow for the medicines that the doctor directs the patient to take or use. After each prescription, there is a term such as "solution" or "pills" to identify the various medicines for the patient's use. If several pills are to be used, they are described as "red pill," "black pill," "white pill," etc.

Following the prescriptions, there is an account of the doctors directions to the patient. These usually start off in the third person, worded very formally as, "the patient will," etc., but frequently the text changes to the second person and becomes an exact quote of the doctor's words. Today, when malpractice problems have made it very important that physicians record

conversations with, and directions to, each patient, Dr. Archer's notations could serve as models.

The first case, "A carious ulcer in the nose," presents a good illustration of the format of these records: "Miss E. Day made application to Dr. Archer Dec. 1792 for an ulcer in her nose of three months standing; a piece of bone had exfoliated and come out of the nostril— she had made application to several physicians without having any advantage. The doctor directed as follows—" Prescriptions follow for a solution, pills, a mixture and an ointment. There are a great deal of shorthand and many symbols in the prescriptions that make it difficult for even a modern physician or pharmacist to decipher them. A primary ingredient in the solution, pills and ointment was mercury.

Following the prescriptions, the record goes on: "Miss Day will rub a piece of ointment large as a bean on her nose three times a day and in about an hour after, or before the use of the ointment, put about half a wash-spoon full of the *solution* with an equal quantity of water and with this syringe the inside of your nose twice a day; if it should excite smarting, add a little more water, but if it should produce no smarting, add a little more of the *solution*. One of the pills is to be taken every night and morning. It would be advisable to syringe your nose three times a day with milk and water and should any of the bones become loose, they must be taken out—you may drink but not wash in cold water—should the outside of you cheek or nose take on inflammation, wet it with the *mixture*. The discharge from the nostrils was very offensive—After a considerable time she lost the bones of her nose and the ulcer healed.—"

Time and space do not allow me at this time to go into the details of all the cases presented in Dr. Archer's notebook; however, in future columns, I will occasionally add a transcription of one of these patients' records and hopefully will be able to decipher the prescriptions to make the record more complete.

The manuscript concludes with copies of several letters, one written by Dr. Archer to a man in Talbot County who had been bitten by a mad dog, and several others from physicians around the United States to Dr. Archer relating incidents in their practices. The letter on hydrophobia is especially interesting and worth recounting. It was written Oct. 6, 1796, to a Henry Holliday, Esq., in Talbot County and reads:

"Sir: W. Grogale has informed me you have been so unfortunate as to have been bitten about 11 days by a mad dog, or rather a dog that did go mad 24 hours after he bit you, and that you are desirous of the mode of treatment to pursue to prevent the bad effects arising from a communication of the virus.

"I have some small hope that as the disease in the dog had not taken place so as to produce the rabies that the saliva of the dog was not sufficient so as to be infectuous; but as this is only founded in opinion and not on facts, it will be necessary that you go thro' a regular course of medicine.

"Before I speak to you the mode of treatment and the medicine to be taken, I shall remark that from a careful attention to a number of cases of persons who have been bitten by mad dogs, I have found the period from the day they were bitten to the day there were evident symptoms of an approaching rabies to be about 42 days. In two cases from the bite of mad cats

to be 55 or 56 days— From these observations, I have concluded that the period is the 42nd or sometime between the 42nd to the 56th days, but I am rather of opinion that the 42nd day is the period of the bite of a mad dog for the rabies to commence in man.

"All diseases that are communicated by infection one person to another, or from one animal to another, have their regular periods from the commencement of the infection to the commencement of the disease and that the periods of different diseases are different and in different genera of animals the same disease has different periods; but the same disease to all the species of one genus as the Rabies Canina in dogs, wolves, etc., as 14 or 15 and in man from 42 to 56 days.—From this view of the nature of diseases from infection will arise a mode of treatment to prepare for the approach of the disease so as to render it in a great measure light and easy—another, the treatment of the disease after it has commenced.

"With respect to the preparatory method in Rabies Canina.—As soon as the person is bit, the part should be well-washed for a considerable length of time and I should prefer common soap and water or a solution of salt of tartar, or common lye made of wood ashes—after it is well-washed, rub plentifully of strong mercurial ointment into the part—rub it well each time twice a day and keep a plaster of it constantly applied to the part—as you are bit in the finger let the finger, arm and auxiliary glands be well-rubbed every morning and evening with the mercurial ointment—every night and morning take a mercurial pill of two grains each until your gums get sore and you begin to spit, then the taking of the mercury is to be so regulated as to keep you spitting moderately for 42 days at least or what is the safest to the 56th day after which there is no danger—about the 36th day an emetic of Mercurius Emeticus flavur (sic) alia Turpeth Mineral is to be given. I would also recommend you to take a dycocion of alecarpane root in the following manner—Take two ounces of alecarpane root, slice or bruise it into small pieces, boil it gently from two quarts of water to one quart and bottle it for use—of this drink a large teacupful for a week and again on the beginning of the sixth week and continue it until after the 42nd day—diet to be light and easy of digestion.

"Sir, for your consolation I can with truth say I have had sundry patients who were bit with mad dogs with the foregoing treatment they all escaped the bad effects of the disease and without scarcely a symptom worthy of notice. I will mention one which was a certain mark of their having received the infection—several of those who were bit altho' the part healed which I always expect it to do it inflamed and formed a small blister about the 42nd day attended with some slight transient pains, but the patients not otherwise materially indisposed.

"The treatment of the disease after the symptoms have commenced—but this I trust and am fully persuaded if you follow the preceeding mode of treatment you will have no occasion for.

"First. Should spasms come on and these be full evidence of a Rabies Canina, then I would recommend bleeding until the patient faint—when he recovers from fainting if there be tension or fullness in the pulse and spasms have not ceased, bleed again until he faint and so until the spasms cease.

"Second. In aid of bleeding if the person can swallow, give a teaspoonful of ophir with 20 dollops of laudanum every two or three hours until the spasms cease, but not until bleeding has been first used. Again, I would recommend the habit of body to be laxative by strong blisters given every day. This last part has been added because I am at a distance, but I feel assured that there will be no appearance to require this last treatment—support a cheerful mind and after the duration of 56 days, let me hear from you and be assured I am with respect your very h'ble serv't, John Archer."

Unfortunately, we are not told the final outcome of Mr. Holliday's treatment.

A manuscript such as this, or any old medical text, can be very amusing. We may shake our heads in disbelief at the proposed treatments and wonder at the self-assurance of these physicians of earlier times who

trusted in these treatments. We may be tempted to marvel at the ignorance of medicine at this time, and perhaps to wonder that *any* of the human race survives today, but we in our "superior wisdom and knowledge" forget that these "prescientific" physicians were successful in their practice. Many of their patients recovered, and some succumbed in spite of treatment. The picture has not really changed much; we have managed to eradicate or cure a large number of diseases, but new ones have arisen to take their places. The great advance of medical knowledge only serves to remind us of our ignorance and to impress upon us the fact that in a very few short years (far less than the almost 200 years that separate us from John Archer, Jr.) physicians will be looking back on today's practice of medicine and marveling that mankind managed to survive in spite of what we didn't know.

JOSEPH E. JENSEN
Librarian



Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of June, 1979.

1. Alpha I-Antitrypsin empyema	24 Citations
2. Treatment of Marfan's Syndrome	12 "
3. Hypothyroidism and hypoglycemia	9 "
4. Therapy for disseminated intravascular coagulation	25 "
5. Use of immune serum globulin to prevent viral hepatitis, type A	21 "
6. Management of hydatidiform mole	18 "
7. Vitamin B12 deficiency in infancy	20 "
8. Monteggia Fractures	19 "
9. Postpartum depression and psychosis	21 "
10. Cytotoxic testing in food allergies	12 "

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library.

ADAM SZCZEPANIAK, JR.
Assistant Librarian

New Book Titles

Available now for your use from the Med-Chi Library.

Anti-Infective Agents

QV	DuPont, Herbert L.
250	Practical Antimicrobial Therapy, New York, Appleton-
.D 938p	Century-Crofts, 1978.
1978	

Community Health Services

WA	Sullivan, Robert Joseph, 1940-
390	Med. Record and Index Systems for Community Prac-
.S 951m	tice. Cambridge, MA, Ballinger, 1979.
1979	
WA	Warren, David G.
33	A Legal Guide for Rural Health Progs., Cambridge,
.AA 1	MA, Ballinger, 1979.
.W 281	
1979	

Delivery of Health Care

- W Mansinghka, Surendra K.
100 **Natl. Health Insurance Issues: Viability of the Cost-**
.M 288n **Sharing Concept**, Nutley, NJ, Roche Laboratories,
1978 1978.

Diagnosis, Laboratory

- QY **Clin. Diag. and Man. by Laboratory Methods**, Ed. by
4.3 John Bernard Henry, 16th ed., Phila., PA, Saunders,
.T 633 1979.
1979

Diagnosis, Surgical

- WO Browse, Norman Leslie
141 **An Intro. to the Symptoms and Signs of Surgical Di-**
.B 885i **sease**, London: Arnold, 1978.
1978

Drugs

- QV Knoblen, James E.
55 **Handbook of Clin. Drug Data**, 4th ed., Hamilton, IL,
.K 72h Drug Intelligence Publications, 1978.
1978

Food Hypersensitivity

- WD Breneman, James C., 1922-
310 **Basics of Food Allergy**, Springfield, IL, Thomas, 1978.
.B 837b
1978

Gastrointestinal Diseases

- WI **Gastrointestinal Disease: Pathophysiology, Diag., Man.**
100.3 Ed. by Marvin H. Sleisenger and John S. Fordtran,
.G 256 2nd ed., Phila., PA, Saunders, 1978.
1978

Health Facilities

- WX Kessler, Marian S.
16 **Comparative Statistics on Health Facilities and Popu-**
.K 42c **lation: Metro. and Nonmetro. Areas**, Chicago, Amer.
1978 Hos. Assn., 1978.

Immunologic Deficiency Syndromes

- WD Society for the Study of Inborn Errors of Metabolism
308 **Inborn Errors of Immunity and Phagocytosis**, Balti-
.S 678i more, University Park Press, 1979.
1977

Influenza

- WC Neustadt, Richard E.
515 **The Swine Flu Affair: Decision-Making on a Slippery**
.N 496s **Disease**, Wash., DC, US Govt. Print. Off., 1978.
1978

Medical Assistance, Title 19

- W **The Medicaid Experience**, Ed. by Allen D. Spiegel.
275 Germantown, MD, Aspen Systems Corp., 1979.
.AA 1
.M 489
1979

Nervous System

- 1979 Chusid, Joseph G.
WL **Correlative Neuroanatomy and Functional Neurology.**
100 17th Ed. Los Altos, CA, Lange Med. Pub., 1979.
.C 563c
1979

Occupational Diseases

- WA Occupational Safety and Health Admin.
400 **Informing Workers and Employees About Occupa-**
.O 15i **tional Cancer**, Wash., DC, Natl. Acad. of Sci., 1978.
1978

Physical Examination

- WB Lewis, Howard P., 1902-
200 **The His. and the Physical Exam.**, New York, Ap-
.L 674h pleton-Century-Crofts, 1979.
1979

Physiology

- QT Best, Charles Herbert, 1899-
104 **Best and Taylor's Physiological Basis of Med. Practice.**
.B 561p 10th Ed., Baltimore, Williams and Wilkins, 1979.
1979
QP Ganong, William F.
34 **Review of Med. Physiology**, 9th Ed. Los Altos, CA,
.G 198r Lange Med. Pub., 1979.
1979

Plants, Toxic

- WD Mitchell, John
500 **Botanical Dermatology; Plants and Plant Products In-**
.M 681b **jurious to the Skin**, Vancouver, Greengrass, 1979.
1979

Practice Management, Medical

- W Balliett, Gene
80 **How to Close a Med. Practice**, Oradell, NJ, Med.
.B 192h Econ., Com., 1978.
1978

Terminal Care

- WX Stoddard, Sandol
28.61 **The Hospice Movement: A Better Way of Caring for**
.S 869h **the Dying**, Braircliff Manor, NY, Stein and Day,
1978 1978. □

Motorcycle Injuries: Articles Available Through the Med-Chi Library

- Compulsory Helmets for Motorcyclists**, (Letter), **N. Engl. J. Med.**, v.300(10):567, March 8, 1979.
- Road Accidents—Seat Belts and the Safe Car**, **Br. Med. J.**, v.2(6153):1695-8, Dec. 16, 1978.
- Motorcycle and Bicycle Accidents**, **Br. Med. J.**, v.1(6155):39-41, Jan. 6, 1979.
- A Survey of Rhode Island Motorcycle Fatalities During 1975-76**, by Losee, J.M.: **R.I. Med. J.**, v.61(9):333-40, September, 1978.
- Easy Rider—Hard Facts: Motorcycle Helmet Laws**, by Russo, P.K.: **N. Engl. J. Med.**, v.299(19):1074-6, Nov. 9, 1978.
- Developments in the Prevention of Road Injuries**, by Bull, J.P.: **Injury**, v.10(1):10-3, August, 1978.
- Off-Road Vehicle Accidents: A New Spectrum of Trauma**, by Charters, A.C. and Schroedl, G.: **J. Trauma**, v.18(8):596-600, August, 1978.
- Motorcycle Accident Fatalities**, **Stat. Bull. Metropol. Life. Ins. Co.**, v.59(2):7-9, April-June, 1978.
- Moped, Minibike and Motorcycle Accidents: Associated Injury Problems**, by Balcerak, J.C. and others, **N.Y. State J. Med.**, v.78(4):628-33, March, 1978.
- Road Accidents—Priorities and Possibilities**, **Br. Med. J.** v.1 (6159):328-31, Feb. 3, 1979.
- Head Protection for Cyclists**, **J. Kans. Med. Soc.**, v.78(12):529-32, December, 1977.
- Design of Motorcycle Crash Helmets**, (Letter) by Hadfield, G.: **Br. Med. J.**, v.2(6078):43, July 2, 1977.
- Motorcycle Helmets and Facial Injuries**, by Vaughan, R.G.: **Med. J. Aust.**, v.1(5):125-7, Jan. 29, 1977.
- Motorcycle and Bicycle Accidents**, (Letter) by Kirkman, N.F.: **Br. Med. J.**, v.1(6157):195-6, Jan. 20, 1979.
- Motorcyclists' Injuries and Crash Helmets**, (Editorial), **Br. Med. J.**, v.1(6075):1491-2, June 11, 1977. □

Did You Know That . . .

. . . wearing a helmet does not hinder vision?

That's right. When standing still, a person has peripheral (side) vision of about 110-115°. When a helmet is put on, the peripheral vision remains the same because certified helmets provide a minimum peripheral vision measuring 120°. This is standing still. Once the cyclist starts riding, his/her area of vision decreases, *but* this is caused by increasing speed (not the helmet) causing a tunnel effect on the cyclist's vision. This happens with *all* moving vehicles, motorcycles as well as cars. The faster you go, the smaller the tunnel and the less you see.

. . . wearing a helmet does not impair hearing?

What a helmet does is provide a screening effect, *but* it screens all sounds to the same degree. Thus, noises that the cyclist doesn't need to hear, such as wind blast, are screened along with other sounds. The cyclist wearing a helmet hears all critical sounds at the same relative strength as the rider without protection . . . except at higher speeds. **THEN THE RIDER WITH THE HELMET HEARS BETTER!** At highway speeds, wind noise becomes a critical factor in the cyclist's hearing. Because the helmet acts as a windscreen, the helmeted cyclist actually hears better at high speeds than the bareheaded rider.

. . . wearing a helmet does not cause neck injuries?

The common argument is that the added weight of a helmet contributes to whiplash injuries; however, whiplash injuries don't happen to cyclists. If a cyclist is hit, the entire body is free to move, but when a car is hit, only the driver's head and neck move violently over the back of the front seat. This snapping action is what causes whiplash. Whiplash injuries are peculiar to car accidents, and, yes, a helmet does add extra weight, *but* only for a day or two; then the neck muscles adjust and you don't feel any "weight problem."

The chances of taking a direct blow on the neck during a fall are pretty slim, but the chances that you'll hit your head are over 50%. Most neck injuries occur when the rider's *head* gets bounced on the pavement, or hits a guardrail or cracks somebody's windshield. If the rider isn't wearing a helmet, a neck injury is the least of his/her problems. It's common knowledge that your head sits on your neck, so if a helmet absorbs the impact that would be taken by your head, it also absorbs the impact that would be taken by your neck. Helmets don't cause neck injuries.

. . . helmets do save lives?

During 1978, motorcycle deaths exceeded 4,300, accidents exceeded 175,000. Of every 10,000 motorcycle registrations, 333 will be involved in an accident. It could happen to you, even though you might not be at fault. Be smart—wear protective equipment—including a helmet.

— — — A message from the Motorcycle Safety Foundation, 780 Elkridge Landing Road, Linthicum, MD 21090. ☐



(Photo by Claude Brooks.)

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Book Reviews

COPING WITH CHRONIC PAIN by Nelson H. Hendler, MD and Judith Fenton. Clarkson N. Potter, Inc., Publishers, 1979.

Reviewed by ELIZABETH B. SHERRILL, MD

(Dr. Hendler is Clinical Director of the Mensana Clinic at Stevenson, MD, a teacher at the Johns Hopkins University School of Medicine and psychiatric consultant at the Chronic Pain Treatment Center of Johns Hopkins Hospital. Judith Fenton is Associate Editor of the *American Medical News*, an AMA publication, and has covered major feature stories and medical news events.)

This 166-page book is for physicians and patients, so the writing is simplified to be understandable to both groups, with definitions and explanations. It describes and defines chronic pain, explains pain pathways, categorizes types of pain and modalities of testing and treatment.

I think that physicians could profit from reading this to help allay some of the frustration of dealing with the problem. We are prone to treat chronic pain with increasing doses of controlled drugs until we have created an addict or else refer and refer until the patient is lost.

The treatment entails the long-term, concentrated effort of the patient and his family with a multi-disciplinary approach until the cause is delineated, followed by a team concept of group therapy with the patient until the pain is removed or allayed and the patient can accept some degree of pain.

The modalities are drug withdrawal from analgesics—minor and major tranquilizers, hypnotics, stimulants, anti-depressants, mood elevators, hallucinogens, muscle-relaxants, antiinflammatory and vasoactive drugs. Anxiety increases pain, so thorazine can be as effective post-operatively as morphine if prior counseling is given. The body contains opiates, the endomorphins and enkephalins, which, if it could be stimulated, could alleviate pain. There is research going on in this area.

There is a chapter on drugs as to how they work and why they are used.

Surgical approach may be percutaneous rhizotomy with thermo-coagulation, or disk removal. Nerve block for diagnosis and treatment, either by incision or excision, can be helpful in selected cases.

Electrical stimulation, either by transcutaneous stimulator which blocks incoming pain messages or by implantation in the back or brain, where the results may be better. Psychotherapy (group and family) with a team approach is useful for the insight into causes of disease pains.

Occupational therapy can help the patient improve skills for a present job or accommodation of motion or to learn new skills for job placement. Behavior Modification in groups can help the patient accept a certain amount of pain. Biofeedback for better awareness

helps to gain relaxation; hypnosis (self) to focus attention elsewhere.

Acupuncture may have a placebo effect, but recent research suggests it may stimulate production of a morphine-like chemical in the body.

Physical therapy to relax the taut muscles (from protective response) or following surgery to increase range of motion and strength is also discussed. ☐

DOCTORS IN THE NEWS:

On July 25, 1979, President Jimmy Carter sent a telegram to Dr. **Richard D. Mudd**, 79, absolving his grandfather, the late Maryland physician—**Samuel A. Mudd**, MD, who died in 1883—from any role in the assassination of President Abraham Lincoln in 1865. *Journal* readers will recall the April, 1976 cover story by Managing Editor Blaine Taylor, **Dr. Samuel A. Mudd's Saga: Was the Maryland Physician a Victim or Part of the Lincoln Assassination Conspiracy?**, in which was described how the late Dr. Mudd set the broken leg of alleged Lincoln assassin actor John Wilkes Booth following the famous shooting in Ford's Theater in Wash., DC. The Saginaw, MI-based grandson, a retired industrial physician, said in the exclusive *Journal* interview that he thought his grandfather would be "Cleared, but not exonerated," which is what President Carter actually did. The Med-Chi Council supported Dr. Mudd's petition to have his grandfather cleared by a Resolution passed Sept. 11, 1971. ☐

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American Medical Association Education and Research Foundation . . . AMA-ERF

AMA-ERF, as we Auxilians know it, is engaged primarily in supporting the cause of medical education; that is to say providing financial assistance to medical students, interns and residents via the Loan Guarantee Fund, and "flexible funds" for the nation's 116 accredited medical schools.

The Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland has the good fortune to have Mrs. Elmer G. (Elizabeth) Linhardt serving as State Chairman of this very important program. Elizabeth's efforts are directed to coordinating, corresponding and communicating on behalf of AMA-ERF with the component Auxiliary Chairmen and Presidents. Because of her own dedication toward the worthy cause of AMA-ERF, she inspires contagious, enthusiastic support for AMA-ERF in every member of the Auxiliary.

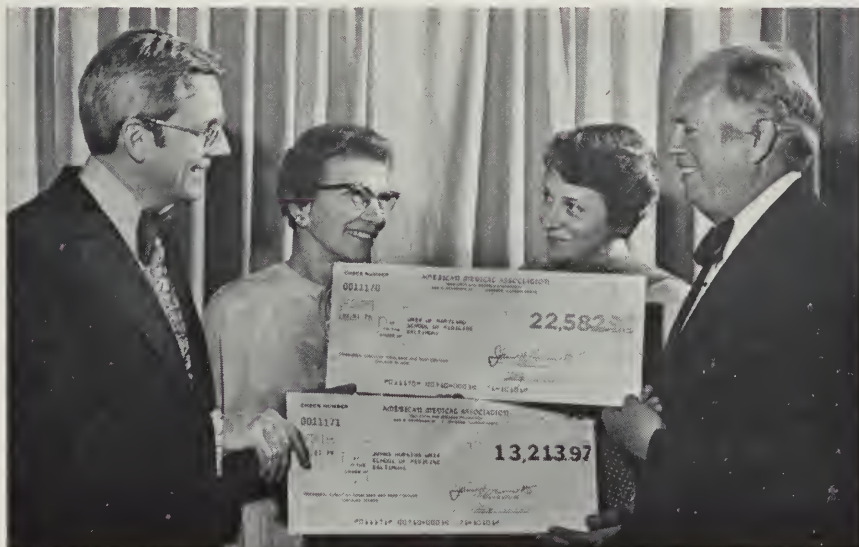
Elizabeth arrived in this position after an interesting lifetime in association with the medical profession. She is of German-American extraction with "roots" in South Baltimore. After a temporary move to Anne Arundel County in her early years, she returned to her native Baltimore and began paraprofessional training at St. Agnes' Hospital. Working in the Outpatient Clinic under the direct supervision of Sister Zoe Shaughnessy, DC, PhG and in the field of Physical Therapy, Medical Technology and Radiologic Technology under Sister Ann Hunter, DC, RT, Elizabeth had exposure to

many eminent Baltimore clinicians of that era, the senior members being Drs. John T. O'Mara, Firmadage K. Nichols, B.E. Seegar, Emil Novak, Austin (Pappy) Wood, George A. Stewart, L. Clarence Cohn and also the "youngsters" of that time: Karl F. Mech, John C. Dumler, George Govatos, Robert F. Healy and Charles R. Marek. Most importantly, Eugene L. Flippin, MD, Radiologist for St. Agnes, contributed much to Elizabeth's education in the field of -ray technology.

A turning point in her career occurred when Elizabeth married Dr. Elmer G. Linhardt following the completion of his internship at St. Agnes' Hospital in 1938, and, once again, Anne Arundel County, specifically Annapolis, became "home." Although Dr. Linhardt became a member of Med-Chi in 1938, Elizabeth did not join the Auxiliary until, as she recalls, "Irene Bauersfeld of Montgomery County was State Treasurer, and dues were \$2 for State and \$1 for National."

She feels "As a physician's wife, it is both a privilege and an obligation to belong to the Auxiliary."

Following a tour of duty during World War II with the United States Air Force, Dr. Linhardt returned to private practice in 1945 and, in the ensuing years, Elizabeth became the dedicated mother of two children. As all her projects in the past have been successful, so these two are rapidly developing also. Angela, their lovely daughter, is a graduate of the Peabody Institute



AT THE 1979 MED-CHI ANNUAL MEETING:

CHECKS from the AMA Educational Research Fund were presented to Dr. J. Richard Gartner, Associate Dean for Administration at the Johns Hopkins University School of Medicine (left) and John M. Dennis, MD (right), Dean of the University of Maryland School of Medicine, by AMA-ERF Chairman Mrs. Elmer Linhardt (left) and Auxiliary President Mrs. Thomas Herbert (right.)

(Photo by Tadder, Balto.)

and is presently teaching piano as a professional. Their son, George Elmer, is in the second year of a surgical residency training program at the University of Maryland.

Keenly interested in the health needs of others, when the children were young students at St. Mary's Grammar School and later St. Mary's High School in Annapolis, Elizabeth is credited with establishing the school's Health Room. This activity required recruiting and training mothers for volunteer staffing of the facility. The program included the audiovisual screening of 800 students annually, with the cooperation of the Anne Arundel County Health Department, which supplied the equipment, in addition to providing TLC for first-graders and bandaids, etc., for the football team. This was a special volunteer activity for Elizabeth for a period of 16 years.

During these years, Elizabeth became a charter member of the Auxiliary of the American Society of Abdominal Surgeons; charter member of the Auxiliary of the International College of Surgeons; an Auxiliary member of Anne Arundel General Hospital and a member of the North Arundel General Hospital Auxiliary as well. Elizabeth has also served the Med-Chi Auxiliary as Members-At-Large Chairman and Treasurer.

Following the example set by her predecessors, Mrs. John (Arlene) Baybut and Mrs. Wallace H. Sadowsky (Bea), Elizabeth has conscientiously dedicated her efforts to AMA-ERF since the beginning of the Auxiliary year 1967-68. "Not by contributions alone" became evident, so following the direction of National Chairmen Lela May Young, Maida Smoth and, later, Ruth Johnson, Edith Lessenden and Kay Reardon, "merchandising for AMA-ERF" became the accepted method of raising supplementary funds for the program. Boutiques sprang up at meetings in every state; locally, through the support of Med-Chi, which generously supplied space, Maryland, too, was afforded the opportunity to "show and sell." The wide variety of items has covered genuine Indian turquoise jewelry, original scrimshaw, Maryland ties, teapots, stationery and watches, to name a few. It is a customary sight to see Elizabeth arrive a day ahead of a meeting accompanied by a multitude of cartons bulging with AMA-ERF merchandise. Raffles—oops! "shares"—have proven a most lucrative method of raising funds. Again, through the generosity of Med-Chi (John Sargeant, specifically), who furnished tickets for trips to Mexico, Bermuda and, more recently, New Orleans, share tickets were circulated, each component auxiliary receiving full credit for its sales. Traditional Christmas cards are an annual project by which physicians and Auxiliary members painlessly support AMA-ERF. This project begins when most of us are thinking of steamed crabs. Careful planning ensures distribution and, as the project progresses, Auxiliary members eagerly await progress reports, hoping to exceed the previous year's record. A variety of continuing projects, such as art auctions, dinner dances, bus trips, Doctor's Day benefits and other major functions, are left to the discretion of each individual component Auxiliary.

Oh! The gigantic, accurate, record-keeping Elizabeth completes is tremendous!

Perhaps a "first" in the history of AMA-ERF, Maryland, through the efforts and guidance of Elizabeth, sponsored an invitational Eastern Region Workshop. We were privileged to have National Chairman Mrs. Quentin L. Quickstad (Barbara) in attendance and conducting the most important aspects of the program, introducing a slide presentation as an additional educational means of emphasizing the need for support of AMA-ERF.

Elizabeth also serves the Faculty as well as the Auxiliary for AMA-ERF. This year's spectacular total of \$27,980.51 achieved by the Auxiliary is summarized thus according to Elizabeth, "The success of 1978-79 clearly demonstrates the importance of TEAMWORK, and you have been an outstanding team to work with." It is energetic, interested people working together which contributes to successful achievement. Compare this year's accomplishment to the goal of 1968, which then was \$7,000. Heartiest congratulations to AMA-ERF and Elizabeth Linhardt.

The greatest recompense of Elizabeth's outstanding volunteer efforts, combined with the support of Faculty members, plus the diligence and energy of Auxiliary members, are summarized in her own words, "The greatest reward will come when the totals are in and you know the great satisfaction achievement." She also regards the AMA-ERF program as "The most meaningful, most rewarding, most frustrating, most demanding and the most challenging of ALL programs in Auxiliary work." Also through her efforts, Elizabeth has earned the respect and admiration of many National officers, as well as other State AMA-ERF chairmen. Her sincere dedication, excellent leadership and superior devotion to the vital need of AMA-ERF is superlative and exemplary to all of us.

This kind of activity by the Auxiliary, guided by an energetic, enthusiastic, dedicated Chairman, is of tremendous importance to those who turn to AMA-ERF for financial support in their pursuit of a medical career, and the dividends of Elizabeth Linhardt's volunteer activities will return to the profession as enthusiastic, energetic young professionals take their places among the ranks of those delivering health care in our nation.

Maryland is scheduled (at press time) to receive two national awards this year at the National AMA Convention, July 21-25 in Chicago; one, "For the state Auxiliary in the Eastern Region with the largest contribution per capita" and as stated by the National Chairman, "I know Elizabeth Linhardt will be particularly happy to see the Auxiliary to the Harford County Medical Society receive the award for the county Auxiliary in the Eastern Region with the largest contribution per capita." Both are coveted awards, for they acknowledge the *individual* accomplishment.

It is Elizabeth Linhardt, our Chairman, whose dedicated, diligent efforts and contagious enthusiasm is spirited for AMA-ERF in every member of the Auxiliary, the medical society, staff and friends. □

Rehabilitation Medicine

FREDERICK J. BALSAM, MD Editor

Spasticity Modified by Obturator Nerve Block

By GERALD FELSENTHAL, MD

Dr. Felsenthal is Associate Chief of the Department of Rehabilitation Medicine at Sinai Hospital of Baltimore and Assistant Professor in the Department of Rehabilitation Medicine at the University of Maryland School of Medicine. Address reprint requests to Dr. Felsenthal at Dept. of Rehab. Med. Sinai Hospital of Baltimore, Belvedere Ave. at Greenspring, Balto., MD 21215.

Abstract

Spasticity is a frequent complication of many diseases of the central nervous system, such as multiple sclerosis. Frequently, a flexed adducted position of the thigh develops which interferes with functional activities and good nursing care. Obturator nerve block (ONB) is a procedure useful for the reduction of this position. In this paper, the gain in thigh abduction and hip extension after complete obturator nerve block was measured. In the absence of contracture, the increase in abduction was between 10-25° and in extension between 10 and 50°. The effect of a block of either the anterior or posterior division alone was also recorded. Measurements also indicated a post-block increase in knee extension of between 4-28°. This is explained by study of the kinesiology of the muscles directly or indirectly affected by the obturator nerve block. The observation of generalized reduction of spasticity after blocking a single peripheral nerve is explained by the interruption of the afferent and efferent fibers of the blocked nerve and by the decreased afferent input from the antagonistic muscles which are no longer being stretched by the spastic contraction of the muscles innervated by the blocked nerve.

Introduction

Obturator nerve block has been utilized primarily as a technique to reduce thigh adduction spasticity, particularly in patients in whom the adducted flexed position of the thighs interferes with functional activities (i.e., ambulation or wheelchair transfers) and/or the goals of good nursing care (cleanliness, continence of urine, prevention of joint contractures and decubiti). This technique has several advantages over other procedures and medication which may be considered in trying to accomplish these same goals (Table One). In addition, it has been a common clinical observation after phenol block of the obturator nerve that flexion spasticity in the hip and knee has also decreased. This is particularly evident when the block has been done before contracture has developed in the thigh adductors and hip and knee flexor muscle groups. The tech-

nique for doing an obturator nerve block¹ and the rationale for selecting phenol as the neurolytic agent have been reviewed in prior publications.² This paper documents the effectiveness of ONB using phenol, as performed by a physician trained in this technique, and offers a rationale for the relaxation observed at joints not primarily affected by muscles innervated by the obturator nerve.

Table One:

Advantages of an Obturator Nerve Block

1. Versus Obturator Neurectomy and/or Adductor Tenotomy for Spasticity or Contracture
 - A. Avoids delay in the rehabilitation program
 - B. Avoids secondary effects of surgery
 1. Inactivity and associated complications
 2. Decreased motor skills and endurance
 3. Possibility of infection
 - C. More readily accepted by patients (especially with multiple sclerosis) than a permanent procedure
 - D. Partial procedure for limited therapeutic effect easily performed
 - E. Easily repeatable procedure when clinically indicated
 - F. Applicable when surgery contraindicated
 - G. Useful in evaluating effects of potential surgery
2. Versus anti-spasticity medication
 - A. Avoids increased generalized weakness
 - B. Avoids possible adverse systemic reactions

Method

The anterior and posterior divisions of the obturator nerve are localized, using an electrical stimulator capable of delivering a pulsating direct current through a hypodermic needle that was coated with teflon except at its tip. After precise localization, phenol was injected into each division of the obturator nerve.¹ Range of motion measurements using goniometric techniques were made pre-and post-block. It was ascertained by repetitive measurements that these goniometric techniques were reproducible within five degrees, though accuracy of and clinical significance of changes of less than five degrees was questionable. The lack of full hip extension was determined by placing and holding the contralateral thigh in the maximum obtainable flexed position, thus straightening the lumbar lordosis. The ipsilateral leg was then placed over the side of the table, thus preventing the heel in the presence of knee flexion spasticity from maintaining the hip in flexion. In this position, maximum hip extension was obtained and recorded as the number of degrees lacking of full extension. Similarly, the number of degrees lacking of full knee extension was recorded. Thigh abduction was measured by forcefully abducting the thigh while monitoring movement of the pelvis.

When the pelvis began to move, the number of degrees of abduction of the thigh was recorded. Measurement was made by subtracting 90° from the angle formed by a line connecting the anterior superior iliac spines and the long axis of the thigh. In three cases, measurements were recorded after block of the anterior division of the obturator nerve as well as after both divisions were blocked. In one case, electromyographic (EMG) monitoring of muscles innervated by the anterior division of the obturator nerve, i.e., the adductor longus, and the posterior division, e.g., the adductor magnus, was carried out. The muscles were localized as described by Delagi.³ Recording was done pre- and post-block using a Teca TE-4 Direct Recording Electromyograph. Muscle activity was stimulated by abducting the thigh.

Results

The gains in range of motion obtained after doing an obturator nerve block in five patients are reported in Charts A through E. In each case, in addition to the expected gain in thigh abduction and hip extension, a gain in knee extension was also observed.

In Patient A (Chart A), measurement was made of the gain in hip extension and thigh abduction after block of the anterior division of the obturator nerve. On the right, the patient gained 18° of extension and five degrees of abduction. After blocking the posterior division, an additional two degrees of extension was obtained and an additional 15° of abduction. On the left, after blocking the anterior division, the gain in

hip extension was 10° and thigh abduction 10°. After the posterior division block, an additional gain of 14° of extension and 10° of abduction was observed. Similarly in Patient D (Chart D), after blocking the anterior division of the obturator nerve on the right, a gain of four degrees of hip extension and 10° of thigh abduction was measured. Blocking the posterior division gave a further increase in hip extension of 18°, but no further increase in abduction. On the left, the gain after block of the anterior division was 10° of hip extension and five degrees of abduction. An additional six degrees of extension and five degrees of abduction was obtained by blocking the posterior division. For Patient E (Chart E), after blocking the anterior division the gain in hip extension was two degrees, and in thigh abduction was five degrees. Blocking the posterior division of the obturator nerve gave a further gain of eight degrees of extension and 10° of abduction. These examples illustrate the importance of blocking both the anterior and posterior division of the obtu-

Chart A			
DIAGNOSIS: Alzheimer's Disease			
PROCEDURE: Bilateral Obturator Nerve Block			
	Pre-Block	Post-Block	Gain
Right Leg			
Thigh Abduction	15°	35°	20°
Hip Extension	Minus 20°	0°	20°
Knee Extension	Minus 40°	Minus 12°	28°
Left Leg			
Thigh Abduction	10°	30°	20°
Hip Extension	Minus 24°	0°	24°
Knee Extension	Minus 46°	Minus 24°	22°

Chart B			
DIAGNOSIS: Paraplegia Secondary to Arachnoiditis			
PROCEDURE: Bilateral Obturator Nerve Block			
	Pre-Block	Post-Block	Gain
Right Leg			
Thigh Abduction	15°	30°	15°
Hip Extension	Minus 60°	Minus 10°	50°
Knee Extension	Minus 35°	Minus 27°	8°
Left Leg			
Thigh Abduction	15°	30°	15°
Hip Extension	Minus 40°	0°	40°
Knee Extension	Minus 45°	Minus 32°	13°

Chart C			
DIAGNOSIS: Multiple Sclerosis			
PROCEDURE: Bilateral Obturator Nerve Block			
	Pre-Block	Post-Block	Gain
Right Leg			
Thigh Abduction	27°	45°	18°
Hip Extension	0°	0°	0°
Knee Extension	Minus 10°	0°	10°
Left Leg			
Thigh Abduction	20°	45°	25°
Hip Extension	Minus 24°	0°	24°
Knee Extension	Minus 18°	0°	18°

Chart D			
DIAGNOSIS: Paraplegia Secondary to Multiple Sclerosis			
PROCEDURE: Bilateral Obturator Nerve Block			
	Pre-Block	Post-Block	Gain
Right Leg			
Thigh Abduction	0°	10°	10°
Hip Extension	Minus 24°	Minus 2°	22°
Knee Extension	Minus 10°	Minus 10°	0°
Left Leg			
Thigh Abduction	0°	10°	10°
Hip Extension	Minus 20°	Minus 4°	16°
Knee Extension	Minus 10°	Minus 6°	4°

Chart E			
DIAGNOSIS: Multiple Sclerosis			
PROCEDURE: Unilateral Obturator Nerve Block			
	Pre-Block	Post-Block	Gain
Thigh Abduction	5°	20°	15°
Hip Extension	Minus 20°	Minus 10°	10°
Knee Extension	Minus 30°	Minus 40°	10°

ator nerve in order to obtain the maximum reduction in thigh adduction and hip flexion spasticity.

Figure one (Patient E) demonstrates the electrical activity of the adductor longus muscle caused by pulling the thigh into abduction prior to and after block-

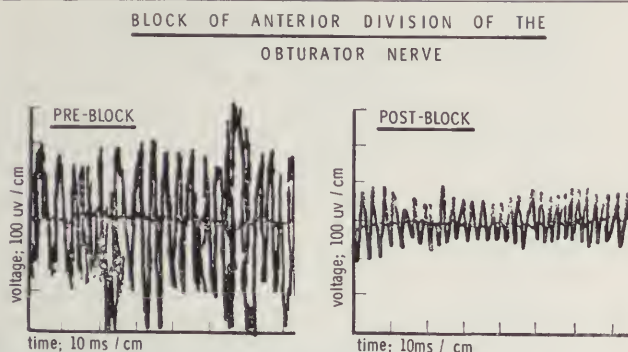


FIGURE 1: Electromyographic activity induced in the Abductor longus muscle by stretch abduction of the thigh pre- and post-block of the anterior division of the obturator nerve.

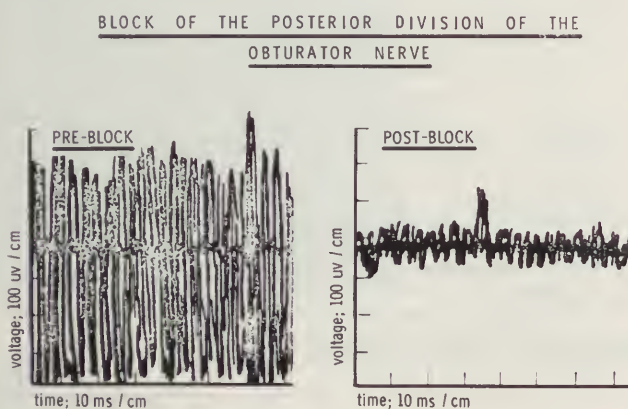


FIGURE 2: Electromyographic activity induced in the adductor magnus muscle by stretch abduction of the thigh pre- and post-block of the posterior division of the obturator nerve.

ing the anterior division of the obturator nerve. The change in activity was observed within less than a minute of the time of injection of the anterior division. Figure Two demonstrates the continued activity in the adductor magnus with thigh abduction after block of the anterior division. This activity also diminished within less than a minute after blocking the posterior branch. Activity of the adductor magnus could still be elicited by obtaining hip extension even after blocking the posterior division of the obturator nerve since this is a dually-innervated muscle that also receives innervation from the tibial nerve division of the sciatic nerve. These recordings reemphasize the necessity of blocking both the anterior and posterior division of the obturator nerve in order to obtain a maximally-effective nerve block.

The three patients with multiple sclerosis were available for follow-up evaluation post-block. The duration of effectiveness of the block until increased thigh abduction and/or hip flexion spasticity necessitated repeat block was a minimum of four-six months. When clinically-indicated, repeat obturator nerve blocks were done with similar decrease in spasticity and duration of effectiveness as initially noted.

Discussion

The increase in thigh abduction and hip extension after obturator nerve block was understood to be a direct result of the peripheral nerve block. Each of the muscles innervated by the obturator nerve, once it enters the thigh, functions as a thigh adductor. In addition, each of the obturator nerve-innervated muscles, also contributes to hip flexion in varying degrees. Brunnstorm⁴ summarizes the flexion contributions of the adductor muscles as determined by Fick.⁵ The pectineus is a flexor in all positions of the hip joint but, as flexion proceeds, the leverage of this muscle as a flexor decreases to the point of no leverage in extreme flexion. Its work capacity as a flexor surpasses its work capacity as an adductor. The adductor longus acts as an adductor in all positions of the joint. It flexes in the first 70° of flexion, but its leverage decreases progressively to the point of no leverage at 70°. The principal action of the adductor brevis is adduction of the thigh. From the hyperextended position to about 50° of flexion, it is a flexor. The main action of the adductor magnus is adduction. In the extended position and up to about 50° of flexion, the upper obturator innervated portion is a flexor. MacConaill and Basmajian,⁶ however, question the flexor role of the adductor magnus. Their electromyographic study of the adductors showed that during flexion of the thigh, the main activity occurs in the adductor longus, while the magnus is often completely silent. Additional increase in hip extension may occur and be explained without any further decrease in hip flexion spasticity. The tensor fascia lata and sartorius are both accessory hip flexors and thigh abductors and neither is innervated by the obturator nerve. Obturator nerve block would not affect the resting length of either muscle, but it can be postulated that the increased thigh abduction after the nerve block would also allow increased hip extension.

The confirmed clinical impression of increased knee extension after obturator nerve block can be explained without postulating any change in knee flexion spasticity. The hamstring muscles (biceps long head, semimembranosus and semitendinosus) are two-joint muscles causing hip extension and knee flexion. With obturator nerve block and without any change in resting length, any relaxation obtained in hip flexion spasticity would allow an increase in knee extension. The role of the gracilis is ignored in this discussion because it is felt to make an insignificant contribution to knee flexion.⁷

Abramson⁸⁻⁹ and Hirschberg⁸ have shown the reduction of electromyographic activity in the rectus abdominis, rectus femoris and gluteus maximus muscles after ipsilateral obturator nerve section or block. The postulated explanation has been the removal of afferent impulses from strongly contracting muscles, thereby reducing overall spasticity. A kinesiology basis is also available to explain their findings. They mention that in denervating or tenotomizing certain muscles of a limb, neighboring muscles may undergo disuse atrophy rendering them less spastic. Furthermore, they point

out that contracting muscle may produce movement of a limb which stretches other muscles. This stretch in turn may account for the EMG activity observed in their studies as the adductor muscles may provide the stretch stimulus for the observed EMG activity in the rectus abdominis and gluteus maximus and, indirectly via the hamstring, the rectus femoris. The adductors are among the anteriorly-placed downward pelvic rotators and thus stretch the upward rotators including the rectus abdominis. The hip flexion action of the adductors may stretch the hip extensors, i.e., gluteus maximus. The knee flexion action of the hamstrings would stretch the rectus femoris and the increased knee extension obtained after obturator nerve block would allow it to relax.

A generalized decrease in spasticity has been observed after block of a single peripheral nerve. Abramson^{8,9} and Hirschberg⁸ explain this generalized reduction in spasticity after obturator nerve block as the effect of afferent impulses mediated through that nerve. Dimitrijevic and Nathan¹⁰ say that a non-specific reduction of the activity of the alpha motor neurons in the spinal cord is achieved by decreasing the afferent inflow to the spinal cord and that this reduction helps restore reciprocal innervations. Khalili and Betts¹¹ postulate that decreased sensory input from a particular area, because of a larger distribution in the internuncial pool of the central nervous system, gives widespread relief of spasticity in the same limb or others. An alternative explanation has been offered in this paper by study of the kinesiology of the muscles innervated by the blocked nerve and the antagonists of these muscles. In all likelihood, the decrease in spasticity is due to the interruption of the afferent fibers from the muscles innervated by the blocked nerve and to the decreased afferent input from the antagonistic muscles which are no longer being stretched by the spastic contraction of the muscles innervated by the blocked nerve.

Summary and Conclusions

In these five patients, obturator nerve block was determined to decrease thigh adduction and hip flexion spasticity directly and to allow increased knee extension indirectly. The explanation for the decreased spasticity is interruption of the afferent and efferent fibers of the blocked nerve and by decreased efferent input from the antagonistic muscles which are no longer being stretched by the spastic contraction of the muscles innervated by the blocked nerve. Clinically, ONB is a technique, in addition to or as an alternative to medication or surgery, useful in treatment of spasticity that is interfering either with function or good nursing care. The duration of effectiveness of the ONB was clinically observed to be four-six months, and it could be easily repeated as indicated by evaluation of the patient.

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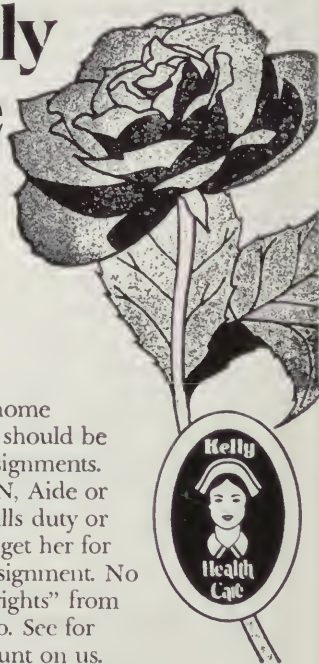
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DOCTORS TAKE NOTE:

Sept. 14-16, AMA Regional CME Mtg., Williamsburg, VA, 13 Cat. 1 Courses: Basic Life Support—CPR; Common Neurological Problems; Acid-Base, Fluid and Electrolyte Balance; Office Dermatology; Basic Electrocardiography, Advanced Cardiac Life Support—CPR, Human Sexuality: Genesis and Therapy of Sexual Dysfunctions, Office Orthopedics, Office Gynecology and Endocrine Problems, Allergy and Immunology, Office Pulmonary Function Testing and Chronic Obstructive Lung Disease, Modern Management of Congestive Heart Failure, Physician's Practice Management—Managing the Business Side. For details, call Lloyd W. Prang, AMA, (312) 751-6000.

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Doctors in the News

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Dr. Joseph E. Whitley, Professor and Chairman of the Department of Diagnostic Radiology at the University of Maryland School of Medicine, has been elected President of the national Association of University Radiologists (AUR) at its recent meeting in Rochester, NY.

Formed in 1953, the AUR consists of over 1,500 academic radi-



DR. WHITLEY

ologists in the US and Canada. In addition to representing academic radiologists as a political entity, the organization publishes a scholarly journal and holds an annual convention.

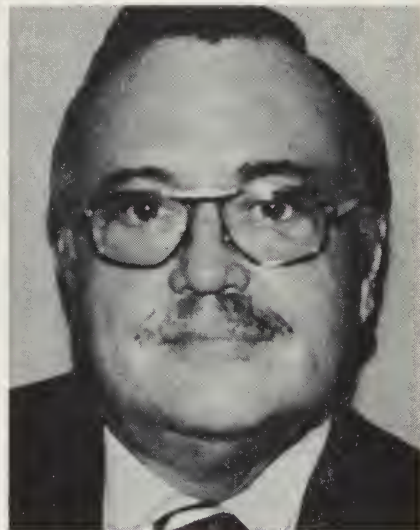
Dr. Whitley joined the University of Maryland School of Medicine in 1978 after a 16-year association with the Bowman-Gray School of Medicine in Winston-Salem, NC. He is a trustee of the James Pickner Foundation, a book reviewer for the *Journal of the American Medical Association* (JAMA), a Fellow of the American College of Radiology and the author of over 50 scientific publications.

Dr. Chambers Made President

Dr. Robert G. Chambers, MD of Baltimore was elected President of the Society of Head and Neck Surgeons at a recent meeting in Pittsburgh. Dr. Chambers is Associate

Professor of Surgery and in charge of the Head and Neck Service at Johns Hopkins Hospital. He is also Assistant Professor of Surgery at the University of Maryland Hospital in Baltimore.

Dr. Chambers also was awarded the Margaret and Norman Gosse Visiting Lectureship in Carcinoma of the Thyroid by the Canadian Cancer Society during the past year. □



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Sept. 19, **Depression and Pseudo-Dementia**, talk by Paul McHugh, MD, Henry Phipps Professor of Psychiatry, JHU Sch. of Med.

Oct. 17, **Life Stages in Adulthood: A Clinically-Relevant Concept?** talk by John B. Imboden, MD. For details, call number above.

Nov. 14, **Prob. of the Hard-Core Chronic Patient**, talk by Fred Pokrass, MD. For details, call above number.

Dec. 12, **Lawyers, Doctors and the Legislature**, talk by Jonathan H. Shoup, JD. For details, call above number.

University of Maryland


Sept. 18, **Current Concepts in Diag. and Trtmt. of Retinal and External Ocular Disease.** Balto., campus. For details, call (301) 528-3956.

Sept. 27-28, **The High-Risk Infant: Who are They and What Happens to Them?** Univ. Med. Campus. For further info. contact the Prog. of Cont. Educ. at (301) 528-3956.

Sept. 27-Nov. 1; **Selected Topics in Family Prac., Part 1**, (Thurs., 5:15-7:45 P.M.) Univ. Med. campus. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.

Oct. 5, **Nutrition**, College Park Campus Adult Educ. Ctr. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.


Oct. 10-12, **Computer Tomography Symp.: Body CT and Neuroradiology**, Internat. Hotel, BWI Airport. For further info., contact the Prog. of Cont. Educ. at (301) 528-3956.



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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing one teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

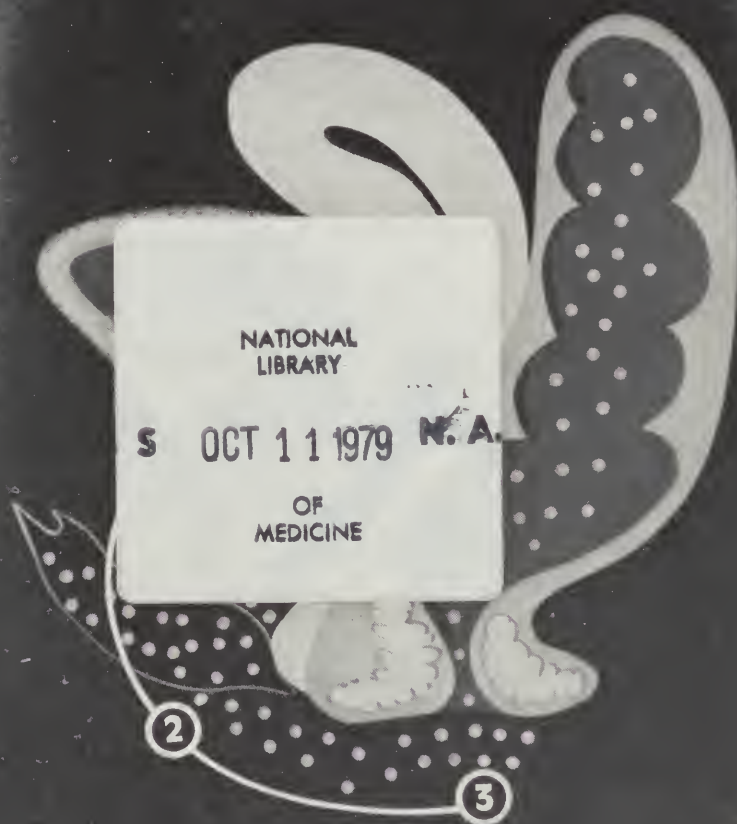


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Please see back cover.

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Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

5724

5,

OCTOBER 1979

MARYLAND STATE MEDICAL



FIRST LADY GREETS "DOCTOR OF THE YEAR" AT THE WHITE HOUSE:

*First Lady Rosalynn Carter shakes hands with Dr. J. Roy Guyther as Dr. W. Jack Stelmach, President of the American Academy of Family Physicians, watches at a July 18, 1979 ceremony at the White House. Dr. Guyther, who is from Mechanicsville, MD, was honored as **Good Housekeeping's** "Family Doctor of the Year," an award given annually by the magazine in conjunction with the AAFP. Dr. Guyther is the third recipient of the annual award, which was first given in 1977. . . . see page 35*

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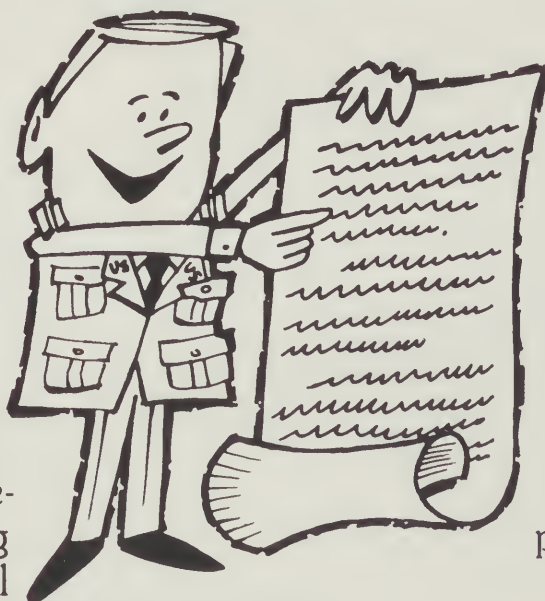
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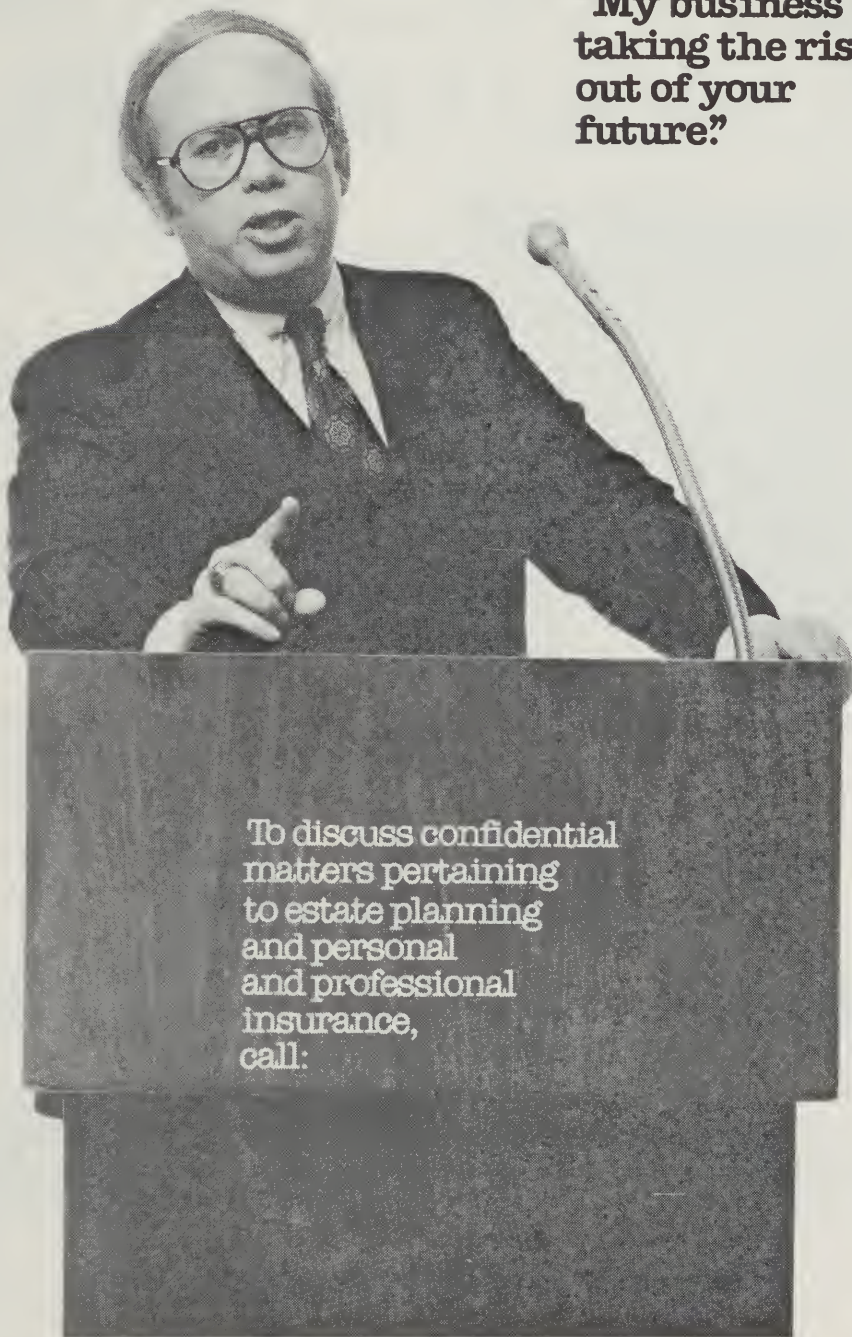
An open letter to Physicians



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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malforma-

tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as heeded and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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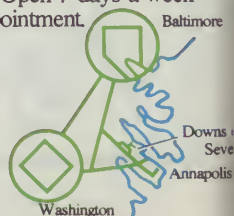
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MARYLAND STATE MEDICAL Journal

Volume 28

OCTOBER, 1979

Number 10

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DR. DONALD S. FREDRICKSON, Director of the National Institutes of Health, is featured in an exclusive profile/interview on page 61 in this issue.
(Photo courtesy of NIH)

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

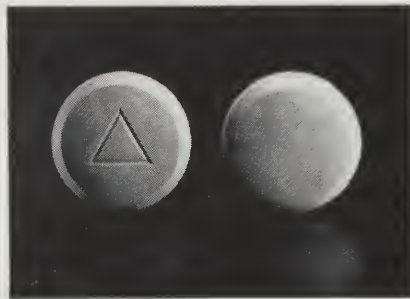
MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: *Generic options almost always exist.*

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: *Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.*

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: *Drugs account for a major portion of the rise in health care costs.*

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: *Government intrusions into the marketplace will save tax money.*

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

The logo for the Pharmaceutical Manufacturers Association (PMA) consists of the letters 'PMA' in a bold, stylized, serif font. The 'P' and 'M' are connected, and the 'A' is separate.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

The Open Forum

Olesker on Dr. Pierpont

To the Editor:

I must comment on Dr. Ross Pierpont's story in your June, 1979 issue, (Ed. note: **The Strange Case of Dr. Pierpont—Could This Happen to You?—BT.**) in which he makes passing—and inaccurate—reference to my alleged role in his legal problems.

According to Pierpont, when I called to question him about his impending criminal indictment, he told me, "Look, if you will treat this off the record and confidential, I will tell you what I know."

At that point, according to Pierpont, I said, "Absolutely," and proceeded to break my word the next day.

I must assume Pierpont is a far better physician than he is a reporter. Let's start with the above colloquy:

There was **never** any mention of going off the record. There are plenty of people who do talk to me off the record, and if Pierpont wants to check with any of them—**any**—he'll find that I keep my word. A reporter who doesn't is headed for a very fast fall.

The truth is, our conversation opened—and, unlike Pierpont, I have notes which I took during our talk—with me saying, "Ross, I have information you're about to be indicted. What's this all about?"

His reply: "Mike, I was gonna call you about that."

(Why he would be calling me on such a matter seemed outlandish. We had neither a professional nor personal closeness, but I let the remark slide.)

He said, "Can I call you back tomorrow and we'll talk about it?"

My reply: "Ross, I'm working on deadline. I've got to talk to you tonight."

No mention of off-the-record. No mention of confidentiality.

I won't quibble with his (partial) account of the remainder of our conversation. He did say something about his attorney, George Russell, working hard on the case. He did mention that he felt it was a case of entrapment. I reported his comments.

What he does **not** mention, in his account in your magazine, is that he told me: "Mike, you're not gonna believe this, but this whole thing is a Communist conspiracy."

Let us leave this bit of lunacy aside for the moment.

The following morning, I telephoned Pierpont's attorney, George Russell, to tell him I had talked to his client and to ask his reaction to the impending indictment.

I took notes on that conversation, too, and here is the dialogue:

Olesker: "George, I talked to Ross last night about this indictment."

Russell: "Oh, no! I told that dunny not to talk to anybody about this. What did he tell you?"

Olesker: "Well, he blames it on the Communists."

Russell: "Oh, no..."

Incidentally, if Pierpont really had asked to talk off the record, and if I had lied to him, is it really likely I would have followed that by phoning his attorney for reaction? Would anybody be so brazen in a "betrayal?"

The fact is, there **was no** betrayal. There was no request for commenting off the record. I was reporting to the public that a prominent member of our community was about to be criminally charged. I was doing my job, and I did it fairly and honestly and thoroughly. I didn't have to call Pierpont at all, but I wanted to allow him the chance to tell his side of the story. I didn't have to call Russell, either, but having heard Pierpont's lame excuse, I wanted to give him one more chance by talking to someone on his side capable of articulating the case more clearly.

One last point: My initial inclination, when reading Pierpont's account, was to brush it off as the sad, twisted delusions of a broken man.

I feel sorry for him. He's a man who worked his way from nothing to a position of high respect in portions of our community, but trying to blame me for his problems is unfair and inaccurate, and I want to set the record straight.


MICHAEL OLESKER

(Managing Editor's Note: During the Pierpont case, Mr. Olesker was a reporter with the **Baltimore News American**, and is now a columnist with the **Baltimore Sun**.—BT.)

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"Further Comment" on Hypnotism . . .

To the Editor:

Blaine Taylor's interview with Dr. Edward O. Hunt, Jr. (**Medical Hypnosis Versus Hypnotism: What They Are—and What They Are Not**, July, 1979) is astute, comprehensive and deserves further comment.

The term, "**hypnotism**" does not refer to the occult. It merely indicates the **study** of hypnosis, or the act or practice of inducing it. A number of texts include the word, "hypnotism" in their titles (Bramwell, Estabrooks and Weitzenhoffer's excellent book). The term "**hypnosis**" is generally used to refer to a **state**, which only resembles normal sleep, but which differs in having been induced by the suggestions and operations of the hypnotist and is different from the electroencephalogram of sleep.

Hypnotism, which began with Mesmer's concept of "Animal Magnetism," has developed into an approach, which emphasizes the psychological processes of the hypnotized patient. It includes motivations, expectations, attitudes, previous experiences with hypnosis, basic trust and the nature of the relationship to the hypnotist (transference-readiness). The needs of each individual patient are significant, and may include masochistic, aggressive, infantile, dependent and sexual need gratifications.

Every physician who uses hypnosis, therefore, must learn all that he can about the patient's "defenses," the manner, in which each patient reacts to him and to the hypnotic induction experience. Does the patient have a fear of losing control, and therefore, resists being hypnotized? Is the patient concerned that he will fail, as he has failed in other aspects of his life, or does he desire to be overpowered? Is he becoming more anxious, as the interpersonal relationship to the doctor-hypnotist develops?

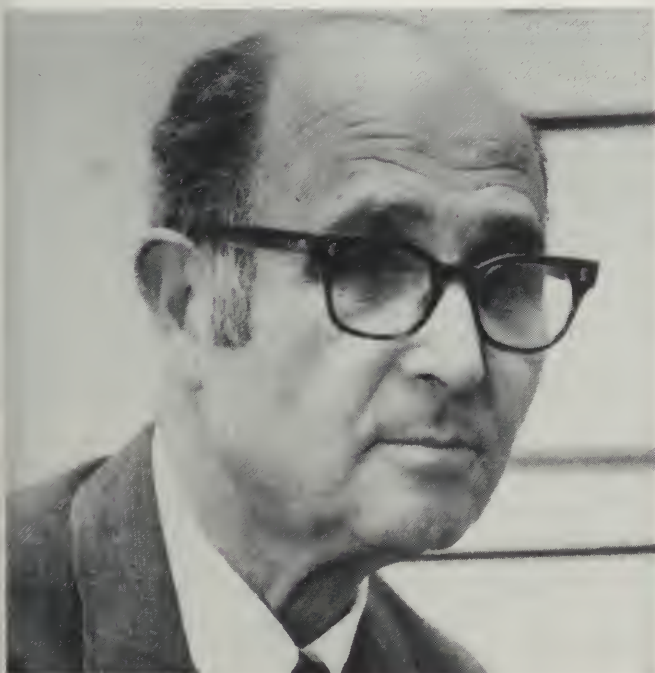
Whether the physician remains a mere technician or becomes an effective medical hypnotist, will, therefore, depend upon his understanding of these motivational, psychodynamic principles. Some suggestible patients cannot be hypnotized, since it is not just a matter of being more suggestible. Hypnosis also includes a capacity to suspend one's critical judgment and the ability to tolerate reality distortion.

The hypnotic state is not fixed or static. It is a particular kind of interpersonal relationship, which quickly develops between the patient and the hypnotist. Each participant influences, and is **being** influenced, by the other. This is just as true in medical hypnosis, as it is in hypnotherapy.

The doctor, who uses office hypnosis, like Dr. Hunt, will frequently be treating Anxiety and Depression, as well as inducing relaxation, when examining the acute or sensitive ("ticklish") abdomen, facilitating the removal of stitches, drains, dressings, the administration of intravenous fluids or maintaining the fixed position of limbs in plastic surgery. Hypnosis has been used in chronic skin disorders, to overcome urinary retention (secondary to spasm and fear), in persistent hiccups, obesity and to overcome the habits of smoking and alcoholism in **selected, good** hypnotic patients.

Hypnosis should always be used with the **full** consent of the patient. The **sicker** a patient is, the **better** a hypnotic patient he will be. Pain is not only physical and mental, it is a form of interpersonal communication—a kind of message, which always includes a demand for relief and comfort. The severely burned patient, the woman in labor and the patient with intractable cancer pain respond effectively to the doctor-patient relationship, which is the **basic** ingredient of hypnotic therapy.

Dr. Hunt is to be congratulated upon his skill and the use of hypnosis in the practice of surgery and medicine. Physicians can bring much comfort and relief of pain to their patients, if they use hypnosis as an



DR. CONN



DR. HUNT

adjunct to the procedures with which they are familiar and competent.

JACOB H. CONN, MD

Past President, Society for Clinical and Experimental Hypnosis
Diplomate American Boards of Psychiatry,
Child Psychiatry and Medical Hypnosis
1190 W. Northern Parkway
Balto., MD 21210.

"... Interest and Nausea ..."

To the Editor:

With a mixture of interest and nausea, I read the prattle of Gerald K. Walters with a newly coined degree, PAC, after his name (Ed. note: Letter, **The Physician Assistant**, in **Open Forum**, July, 1979—BT.) I am a little puzzled as to why organized medicine and its publication should countenance such stuff to the degree that it would see fit to put it in a journal.

For many years, we nurses have worked closely with physicians and required no fanfare, special recognition or compensation above what an ordinary nurse would get. Of course, there are mavericks in our ranks such as the nurse practitioner. The whole thing reminds me of the story of **The Arab and the Camel**, which every school child has heard at one time or another.

The advent of our medical brethren from the North of us, from the South of us, and from overseas that we call our FMGs plus the great number now being graduated from our own schools, would seem to preclude the possibility of needing these auxiliaries.

Privately, physicians will state that they fear they have created a monster and seem to think that one day they will become strong enough to request some form of licensure to perform on their own.

Good doctors, look not at short-term gains, but to the future, and it is later than you think!

BEVERLY E. WILLIAMS RN, BS, MED

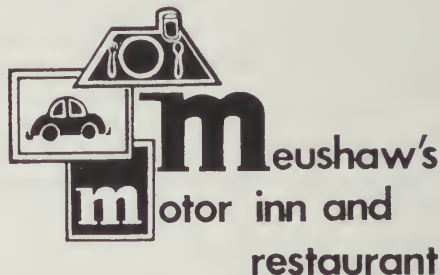
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Editorial: In What Direction?

It is with a modicum of satisfaction that I write this Editorial, for how often in a lifetime can one say "I told you so." Beginning 10 years ago, and this can be documented by a series of articles which were published, attention was called to the fact that there was too much testing in terms of laboratory and, later, the more sophisticated remarkable instruments, such as what was then termed the gastroscope, now referred to as the endoscope and, of course, the scanning and multiple other procedures which have since then been developed. These procedures are very expensive and I was impressed, as were numerous other observers, that a contribution to the escalation of medical costs was generated by doctors, who ordered these tests, who repeated them sometimes over and over, who often did not seem to know what the real indications were for some of the more specialized procedures and, therefore, there accumulated in the record a beautiful, thick chart which, in many instances, swerved from the patient's complaint and the immediate reason for the patient's admission. I have seen and can document that some abnormal findings by the computer were often treated, apart from the fact that they did not relate to the patient's condition and could, in fact, be laboratory errors. I have witnessed, in doing my consultations, many evidences of patients who have been tested beyond imagination without any convincing documentation in the chart that a careful, meaningful history was taken, nor was there a careful development of the patient's symptom complex, nor were there meaningful or legible progress notes. This led, at one time, to the writing of a short article on **The Diagnostic Sentence** in which it was stressed that if a doctor sat down with the patient and took a proper history, carefully-directed into meaningful channels, he/she could be handed a diagnosis by the patient instead of doing what is being done to this day, i.e., hoping that, by numerous testings, the brain will be relieved of its ability to make a diagnosis and that perhaps the hopper will produce the diagnosis.

Now we have cost containment committees at every level, from the city societies to the state societies to national societies, all agreeing that the doctor, who, one must admit, generates costs, can also control them if he/she took time to diagnose and treat human beings (patients) rather than consider them as objects for testing. Most doctors have no knowledge of the costs of the examinations they are ordering and some, who are expert at certain procedures, will continue to do them almost routinely or upon request.

My original observation had to do with the endoscopic procedures because I thought that too many of them were being done even when the diagnosis was already in the record, and it should be added that the cost for these procedures is no small amount. This same criticism applies to CAT (Computerized Axial Tomography) scanning, although I understand that there is a movement on the part of the heads of departments in some institutions which do CAT scanning that such procedures will not be done unless there is a real indication. Other diagnostic imaging procedures overlap to an extraordinary degree (except the superspecialist) because, when available, they are done, although here, too, there is overlapping and no selectivity.



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I believe, basically, that procedures, and especially expensive ones, should be selectively done. There should be no blanket permission to do them on minimal or routine grounds. I also believe that when the hospitals were made to do audits, these audits often resulted in the performance of practically every test on the audit because without such "complete" investigations, the doctor would have been considered to be delinquent in his/her workup of the patient. Audit reviews were compulsory, the order coming down from a higher level, but now they have been dropped and we have focus reviews which, I believe, are beneficial, but they also set up certain routines. These routines should be followed for a while until the lesson is learned, but then there should be such a quality of medicine practiced that the well-trained physician is able to do the necessary testing as he/she needs it, but again remembering above all that he/she is treating human beings, which means more than test procedures.

It is a pity that the art of the practice of medicine has lost so much ground to the technological, perhaps overly-scientific, approach not only in terms of diagnosis, but also in terms of therapy because, when one errs, the other must. Remember, I am not objecting to progress in medicine and I acknowledge the need for research and development, but I **do** object to overutilization or poorly-directed utilization. I, for example, said at one time that a subspecialty such as gastroenterology should not become a technological procedure such as endoscopy, and yet, today the average request for a consultation in gastroenterology is as much, if not more, for the instrument than for the doctor's experience and medical knowledge.

Many outstanding names in the field of medicine agree with the view I am expressing here and have made known their profound dismay because they feel as I do that we are, after all, responsible for the medical care of human beings, and **human being means dialogue, listening and, in a word, understanding** the patient or person who is surrounded with multiple problems in an unstable world. It is for this reason that I entitled this Editorial "**In What Direction?**"

I should add that the Medical and Chirurgical Faculty's Ad Hoc Committee (of which I am a member) "To Implement the Intent of Resolution 1S/77" is helping to answer the question, "In What Direction?" It held its first meeting on Nov. 11, 1977 and has been meeting regularly and conscientiously since that date under the able Chairmanship of Harry F. Klinefelter, MD. Resolution 1S/77 was adopted as amended by the House of Delegates at its Semiannual Session of Sept. 17, 1977. I believe it is important to refresh everyone's mind as to the content of Resolution 1S/77. It reads:

"WHEREAS, The cost of health care is increasing at an alarming rate, faster than other costs in this inflationary economy; and

WHEREAS, Medicine is a field where new techniques and methods increase the number of workers, in contrast to most industries, where new methods reduce the number of workers; and

WHEREAS, Most patients are covered by either private insurance or government funds, and, therefore, do not

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directly pay or even know their hospital costs and

WHEREAS, The greatest increase in health care costs is in the hospital component and

WHEREAS, Physicians are responsible for admission of patients to hospitals and the ordering of ancillary tests performed in the provision of care to such patients therefore, be it

RESOLVED, That medical school faculty members and the practicing physicians of Maryland are urged to become more cost-conscious and to reemphasize the use of the utmost discretion in admitting patients to hospitals and in ordering ancillary services in patient care.

ORDERED, That the President appoint a special committee to implement the intent of Resolution 1S/77."

Problems seem to grow in today's world; it is a credit to this Ad Hoc Committee that after one and a half years (with much to show in the way of accomplishments) it continues to function effectively.

SAMUEL MORRISON, MD

Editorial: AMA-ERF

Medical-student loans guaranteed by the AMA Education and Research Foundation are important in themselves—and also for a reason that goes beyond money.

This reason is that they demonstrate—in clear, bottom-line terms—that our AMA federation is interested in nurturing tomorrow's physicians.

Since the program's inception in 1962, some 75,000 loans totaling over \$90 million have been guaranteed.

Lately, however, the program's resources have been severely pinched. The demand for loans has been mounting—to a great extent because Federal and other sources of financial assistance for medical education have been drying up while the educational expenses continue to escalate.


Last year, more than 4,000 students and physicians-in-training borrowed through the ERF program. This year there can be no more than 2,000.

It would be a sad day indeed if the program were to languish for lack of sufficient resources to meet the loan demand. In the words of AMA Executive Vice President James H. Sammons, MD: "The program of aid dramatically affirms medicine's confidence in, and unselfish support for, the future of health care in America. The physician contributors and their spouses of the Auxiliary, whose dedicated efforts and generous gifts over the years have provided the resources and energy that make the program live, merit special recognition."

Just a little extra effort from medical families and from all of the state and county societies would do much to proclaim that confidence in our health care's future.

Our Maryland Med-Chi Auxiliary has established an outstanding track record of AMA-ERF support. With a little more effort, Maryland could become the leading supporter of this noble cause. Why not? Maryland medical families have often led in developing, supporting and promulgating that which is good about medicine.

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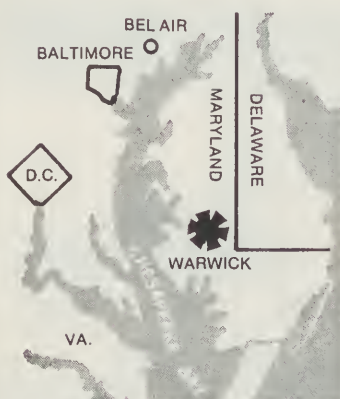


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Executive Director's Newsletter

October, 1979

JCAH The following Maryland hospitals are scheduled for regular
SURVEYS JCAH (Joint Commission on Accreditation of Hospitals) surveys
in the near future:

Children's Hospital	Baltimore
Good Samaritan Hospital	Baltimore
James Lawrence Kernan Hospital	Baltimore
Maryland General Hospital	Baltimore
University of Maryland Hospital	Baltimore
Clinical Center National Institute of Health	Bethesda
Southern Maryland Hospital	Clinton
Union Hospital	Elkton
Washington County Hospital	Hagerstown
Peninsula General Hospital	Salisbury

The JCAH is soliciting comments or problem situations at any of these facilities so they may be considered at the survey time. Data should be sent to:

John E. Milton, Deputy Director
Hospital Accreditation Program
JCAH
875 N. Michigan Avenue
Chicago, Illinois 60611
Phone: 312-642-6061

NEW In response to increasing inquiries regarding ownership,
BOOKLET availability, and rights to review patient medical records,
the Faculty has prepared a booklet outlining current legal
and ethical requirements in this regard.

AVAILABLE Copies may be obtained by contacting the Faculty office,
301-539-0872.

1980 The 1980 Annual Meeting of the Faculty will be held at the
ANNUAL Baltimore Convention Center, Wednesday, April 23 through
MEETING Friday, April 25, 1980. Arrangements have been made to
provide free parking for all attendees at nearby public
facilities. More details will be provided later to all
members.

RESOLUTIONS Deadline date for receipt of resolutions for consideration
DEADLINE at the 1980 annual House of Delegates session is:

FRIDAY, FEBRUARY 29, 1980.

Receipt in the Faculty office must be by close of business on that date.

RUSSELL

Russell S. Fisher, MD, a Faculty Past-President and for several years a Delegate to the AMA House of Delegates, has announced his candidacy for a three-year term on the AMA Board of Trustees. The term, if he is elected, would commence following the adjournment of the AMA House of Delegates in July, 1980.

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SCHOLARSHIP

The Harford County Medical Society Auxiliary has designated a Scholarship Fund in the name of Mrs. Carol Broadus, who died in August, 1979. Mrs. Broadus served as President of its Auxiliary and also the Faculty's Auxiliary.

DESIGNATED

MED/MUTUAL

The Medical Mutual Liability Insurance Society of Maryland is scheduling a program for physicians from the Eastern Shore at the Avery W. Hall Auditorium, Peninsula General Hospital, Salisbury, Maryland, on

PROGRAM

SATURDAY, OCTOBER 20, 1979.

Registration will begin at 9 AM and the program will adjourn at 4:30 PM. There is no registration fee.

The Risk Management/Medical-Legal seminar, which qualifies for Category I CME credit, will cover the following subjects:

1. Coverage under a professional liability policy
2. Early reporting of claims
3. Functions of Claims Department
4. Informed consent
5. Medical records
6. Risk management in the hospital
7. Medical-legal problems
8. Trial problems

Invitations have been mailed to those physicians on the Eastern Shore who may be interested in attending this informative session.

SCHOLARSHIP

Elsie M. Goldstein, wife of a former Faculty President, Albert E. Goldstein, MD, and mother of Robert B. Goldstein, MD, died last month. Contributions are being received for a scholarship fund in her memory. Checks should be made payable to AMA-ERF and mailed to the Faculty office. Contributions are tax-deductible.

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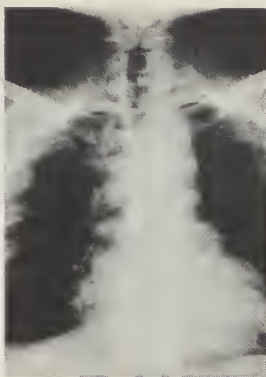

Executive Director

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Maryland-DC Society of Rehabilitation Medicine
Maryland Orthopedic Society
John Staige Davis Society of Plastic Surgeons of Maryland
Maryland Radiological Society
Maryland Society of Allergy
Maryland Ophthalmological Society/Maryland Academy of Ophthalmology
Maryland Dermatological Society
Public Relations Committee
Committee on Physician Rehabilitation
Occupational Health Committee
Maryland Psychiatric Society
Maryland Society of Gastrointestinal Endoscopy
Maryland Society of Cardiology

•

The above program is subject to change. Watch for further details in upcoming issues of the **Journal**.

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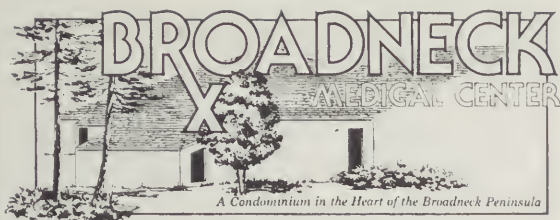
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Plans are underway for Med-Chi's biggest and best Annual Meeting, which will be held in the beautiful, new Baltimore Convention Center, at Pratt and Sharp Sts. in the exciting Baltimore Inner Harbor. PARKING IS AVAILABLE NEARBY . . . DETAILS TO FOLLOW IN UPCOMING ISSUES OF THE **JOURNAL**.

Mark the dates on your calendar NOW: Wednesday, Thursday, Friday, Apr. 23, 24, 25, 1980.

WILLIAM A. PILLSBURY, MD, President
EMIDIO A. BIANCO, MD, Chairman
Committee on Program and Arrangements





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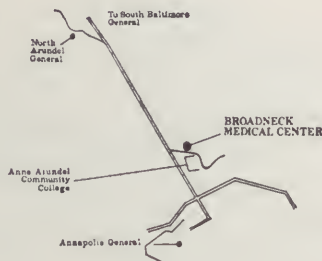
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Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL.

IN THE MATTER OF AUGUSTIN DORDAI, MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention, the Commission on Medical Discipline initiated an investigation into the obstetrical and gynecological practice of Augustin Dordai, MD, by the Peer Review Committee of the Baltimore County Medical Society. Thereafter, the Commission on Medical Discipline (the "Commission") determined to charge Respondent with certain violations of the Code. The violations charged involved the following sub-section of Article 43, §130(h):

(18) Professional incompetence.

Appropriate notice of the charge and the grounds from which it arose was given to the Respondent and a formal hearing on said charge was scheduled before the Commission on March 6, 1979 at 2 PM. In deference to the request of Respondent's attorney to proceed informally, the proceeding was changed to an informal hearing. The Respondent appeared represented by Harrison Stone, Esq. Stephen J. Sfekas, Assistant Attorney General, represented the Commission. Jack C. Tranter, Assistant Attorney General, advised the Commission on rules of evidence. Drs. Dixon and Ehrlich, as prospective monitoring physicians, also appeared.

At the time of said hearing, the Commission agreed to enter into the following Consent Order with the Respondent.

Findings of Fact

The Commission finds that:

1. The Respondent's hospital records reviewed for obstetrical and gynecological patients are unacceptable.
2. The Respondent's written evaluations of obstetrical patients are cursory and incomplete.
3. The Respondent has failed to perform necessary prenatal tests on some obstetrical patients.
4. The Respondent's use of oxytocic agents is not medically acceptable.
5. The Respondent's use of the classical Caesarean section rather than the low transverse section is not medically acceptable.
6. The Respondent failed to detect significant prenatal difficulties in his obstetrical patients.
7. The care Respondent has rendered on occasion to obstetrical patients is not medically indicated.
8. The Respondent has performed surgical procedures which are not medically indicated.
9. The obstetrical care of the Respondent rendered for Harshado Parekh and her sons, Miland B. Parekh and Mihir Parekh, deceased, is not medically acceptable.
10. The Respondent lacks sufficient medical knowledge and diagnostic skills for the type of independent medical practice in which he is currently engaged.
11. The Respondent cannot be permitted to continue the practice of medicine without close monitoring.

Conclusions of Law

Based on the foregoing Findings of Fact, this Commission accordingly adjudicates the Respondent guilty of the charge of professional incompetence.

Order

Upon the foregoing Findings of Fact and Conclusions of Law it is this 6th day of March, 1979, by the unanimous vote of the members of the Commission on Medical Discipline hearing this case

ORDERED that the Respondent is hereby Reprimanded and placed on probation subject to the following conditions:

1. That Respondent shall obtain, at least 100 hours of Category I Continuing Medical Education in the fields of obstetrics and gynecology in each year; and

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2. That each of Respondent's obstetrical cases shall be reviewed prior to the time of delivery by the Chief of Obstetrics at the hospital at which the delivery is to be performed or by a physician designated by the Chief of Obstetrics and acceptable to the Commission provided that this provision shall not apply to patients in spontaneous labor with vertex presentation who were to have been delivered spontaneously, with or without low forceps.

3. That each of the Respondent's gynecological surgical admissions must be reviewed and, if necessary, the patient examined by the Chief of Gynecology at the hospital at which the surgery is to be performed or by a physician designated by the Chief and acceptable to the Commission, prior to the time of surgery in order to confirm the indications and need for surgery.

4. That the Respondent arrange with the Chiefs of Obstetrics and Gynecology at any hospitals at which he practices or may practice that the Chiefs or physicians designated by the Chiefs in accordance with paragraphs 2 and 3 above shall submit quarterly reports to the Commission concerning the Respondent's practice.

5. That the Respondent shall arrange for the Peer Review Committee of the Baltimore County Medical Society to review the Respondent's practice on a semi-annual basis and to submit a report on each such review of the Respondent's practice to the Commission; and be it further

ORDERED that if Respondent violates any of the foregoing Conditions of Probation, if a report submitted by the Peer Review Committee indicates that he is not practicing competently, or if a report submitted by the physician who observes his hospital-based surgery indicates that he is not performing competently, after notification and a hearing, the Commission may revoke the Respondent's license or impose any other disciplinary sanction it deems appropriate; and be it further

ORDERED that three years after the date of this Order, the Commission will entertain a petition to terminate Respondent's probationary status. At such time, if the Commission believes that complete reinstatement would not be appropriate, it may alternatively consider a request to modify one or more of the conditions of Respondent's probation; and

ORDERED that a copy of this Order be filed with the Board of Medical Examiners in accordance with the Maryland Code, Article 43, Section 130(m).

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

Consent

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. Although I do not acknowledge that the Findings of Fact and Conclusions of Law upon which the Commission has based its Order are correct. I do acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, and to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation, I may suffer the revocation of my license to practice medicine in Maryland.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

AUGUSTIN DORDAI, MD

STATE OF MARYLAND, CITY OF Baltimore, to wit:
I HEREBY CERTIFY, that on this 6th day of March, 1979, before me, the subscriber, personally appeared AUGUSTIN DORDAI, MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

ERLINE B. JOHANSEN

NOTARY PUBLIC

My Commission expires: 8/1/82

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Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention and pursuant to Article 43, Section 130 of the Annotated Code of Maryland, the Peer Review Committee of the Medical and Chirurgical Faculty of Maryland initiated an investigation into the medical practice of the Respondent, Sing Eung Kim, MD with the assistance of the Allegheny County Medical Society and with the full assistance and cooperation of Dr. Kim. Thereafter, the Commission on Medical Discipline determined to charge Sing Eung Kim, MD with certain violations of the Code. The violations involve the following subsection of Article 43, Section 130(b):

(18) Professional incompetence.

Appropriate notice of the charges and the grounds from which they arose was given to the Respondent and a hearing on said charges was scheduled before the Commission on Sept. 27, 1977. The Respondent was unable to attend the meeting because of a serious illness, but his attorney, appeared on his behalf and made known Dr. Kim's willingness to enter into a consent order as proposed by the Commission.

Accordingly, the Commission finds that:

- (1) Dr. Kim is engaging in the practice of family medicine;
- (2) Dr. Kim's medical training is exclusively in the areas of pathology and otolaryngology;
- (3) Dr. Kim is not competent to engage in the practice of family medicine;
- (4) The Commission has received no indication that Dr. Kim is incompetent to practice pathology;
- (5) Dr. Kim is board certified in anatomical pathology and is board eligible in clinical pathology. Since the date of the aforesaid meeting, Dr. Kim has taken and passed the clinical pathology examination and is now Board certified.

Conclusions of Law

The Commission, therefore, concludes as a matter of law, that the Respondent was guilty of the charge of professional incompetence.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 10th day of February, 1978, by the unanimous vote of the members of the Commission on Medical Discipline hearing this case,

ORDERED, that effective February 10th, 1978, the license to practice medicine and surgery in the State of Maryland heretofore issued to the Respondent, Sing Eung Kim, MD, by the Board of Medical Examiners is hereby REVOKED; and be it further

ORDERED that the aforesaid revocation shall be STAYED on the following conditions:

1. That Dr. Kim shall cease the practice of family medicine 30 days from the effective date of this Order.
2. That Dr. Kim shall not resume the practice of family medicine unless and until he has completed, to the Commission's satisfaction, a residency program acceptable to the Commission, in family medicine or internal medicine.
3. That Dr. Kim continue to practice medicine as a pathologist provided that his practice may be reviewed by the Commission or its designee from time to time in the Commission's discretion.
4. That if Dr. Kim should decide to discontinue the practice of family medicine permanently and to confine his practice to pathology and shall give satisfactory assurances to the Commission of such a decision, that he may petition the Commission one year from the date of this Order to lift the revocation and to reinstate his license to practice medicine in the State of Maryland and be it further

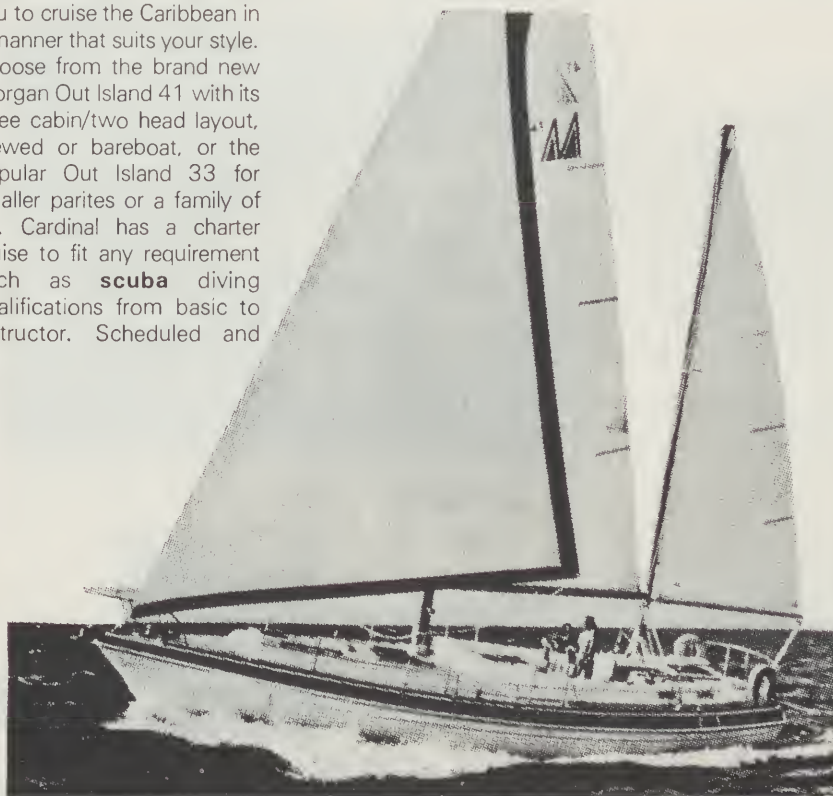
ORDERED that a copy of this Order be filed with the Board of Medical Examiners of Maryland in accordance with the Maryland Code, Article 43, Section 130(m).

JOHN ADAMS, MD, Chairman

Consent

I ACKNOWLEDGE that I have determined to accept and submit to the above Order. By doing so, I acknowledge that I have waived my right to a full evidentiary hearing before the Commission, and accept the above Findings of Fact, Conclusions of Law and Order as if the same had resulted from a hearing at which I would have been able to

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defend myself through counsel against the charges against my medical license. I further recognize that failure to abide by the conditions of my probation may result in the withdrawal of the STAY of the REVOCATION of my medical license.

SING EUNG KIM, MD

Subscribed and sworn to before me, this 30th day of January, 1978, by Sing Eung Kim, MD, as his voluntary act and deed.

Notary Public

□

IN THE MATTER OF ANSELMO ALLIEGRO, MD BEFORE THE COMMISSION ON MEDICAL DISCIPLINE

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention pursuant to the provisions of Article 43, Section 130 of the Annotated Code of Maryland, the Peer Review Committee of the Baltimore County Medical Association initiated an investigation into the medical practice of the Respondent, Anselmo Alliegro, MD. Thereafter, the Commission on Medical Discipline of Maryland, after considering the report and recommendation submitted by the Peer Review Committee, determined to charge the Respondent with certain violations of the Code. The violations charged involved the following subsection of Article 43, Section 130(h):

(18) Professional incompetence.

Appropriate notice of the charges and the grounds from which they arose was given to the Respondent and a hearing on said charges was scheduled to be held on September 5, 1978. Prior to the convening of that hearing, the Commission was contacted by M. Peter Moser, Esquire, the Respondent's counsel, with regard to the charges. Following discussions between Mr. Moser and Jack C. Tranter, Assistant Attorney General, counsel for the Commission, the Respondent agreed to plead guilty and to enter into a Consent Order as proposed by the Commission.

Findings of Fact

The Commission finds:

- 1. That the care rendered by Respondent for Ida M. Watts is not medically acceptable.
- 2. That the Respondent's medical records which were reviewed by representatives of the Peer Review Committee in February, 1978 were not then consistent with the standards required of a competent practitioner of internal medicine.
- 3. That a review of the Respondent's practice by the Peer Review Committee in August, 1978 indicates that the Respondent's record-keeping has significantly improved and that the Respondent's record-keeping is now acceptable.

Conclusions of Law

Based upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the charge of professional incompetence has been substantiated and the Respondent is GUILTY of that charge.

Order

From the foregoing Findings of Fact and Conclusions of Law, it is, this 5th day of September, 1978, by the unanimous vote of seven members of the Commission on Medical Discipline

ORDERED, that the Respondent is hereby REPRIMANDED; and be it further

ORDERED that the Respondent is hereby placed on PROBATION for a period of three years based on the following conditions:

- 1. That the Respondent shall submit to continuing quarterly review of his practice by the Peer Review Committee of the Baltimore County Medical Association.

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2. That the Respondent shall request that the Peer Review Committee forward reports to the Commission following its review of the Respondent's practice.

3. That the reports submitted to the Commission by the Peer Review Committee shall indicate that Respondent is practicing medicine in a competent fashion and be it further

ORDERED that if the Respondent violates any of the foregoing conditions of probation, the Commission may charge Respondent with violations of Section 130h and notify him of the grounds therefor. If, following a hearing in accordance with Section 130, the charges are substantiated, the Commission may revoke or suspend the Respondent's license to practice medicine or further reprimand him subject to the provisions of Section 130 and be it further

ORDERED that one year after the date of this Order, the Commission will entertain a petition to terminate the Respondent's probationary status; and be it further

ORDERED that a copy of this order be filed with the Board of Medical Examiners of Maryland in accordance with Article 43, Section 130(m) of the Annotated Code of Maryland.

JOHN E. ADAMS, MD
Chairman

Consent

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal from the within Order of the Commission. By this Consent, I waive all such rights and acknowledge that by my failure to abide by the conditions of my probation I may be charged with further violations of Section 130h and, if such charges are substantiated, suffer the revocation or suspension of my license to practice medicine in Maryland or be further reprimanded.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

ANSELMO ALLIEGRO, MD

STATE OF MARYLAND, CITY/COUNTY OF Baltimore: TO WIT:

I HEREBY CERTIFY that on this 5th day of September, 1978, before me, the subscriber, personally appeared ANSELMO ALLIEGRO, MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

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Notary Public

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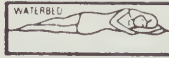
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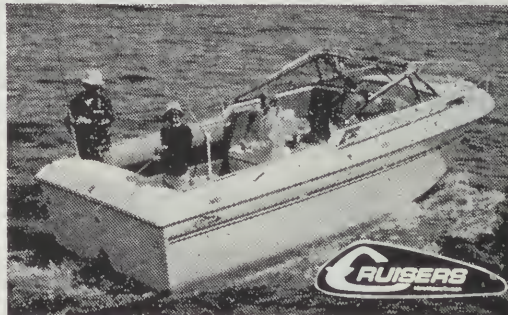


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Editor

At its July 22, 1979 meeting, the Board of Directors approved the appointment of Leon G. Sheer, MD, to the Professional Relations Committee to finish the unexpired term of Robert E. Martin, MD.

Committee Reports

John Mulholland, MD, Chairman of the Public Relations Committee, presented his Committee's report and elaborated each of its many features. He announced that **Project Adoption** of the Primary Alcoholism Treatment (PAT) Center by BCMS was formalized and the agreement had been signed by President Albert M. Antlitz, MD. BCMS will be a facilitator of logistics with the PAT Program. Our Auxiliary will probably give much help. A Subcommittee on History of the Public Relations Committee is considering, with City government, elaborations of significant historical medical events with a Baltimore linkage. Being considered are, for instance, the sick bay on the **USS Constellation** with a display of health practices of the time, and also evolution of Med-Chi as an effort toward Continuing Medical Education for practicing physicians.

Progress on the Committee's exhibit for the Baltimore City Fair was reviewed. Problems of alcoholism and alcohol abuse will be featured. Breathalyzer tests will be available. It will emphasize that alcoholism is a **curable** disease.

Vincent Fitzpatrick, MD, representing the Public Health Committee, reported that the concept of having a women's physical fitness fair had mushroomed, under the stimulation of the City Health Department and the Mayor's Office, into a fitness/wellness fair for the entire community. The Directors agreed to this change and also voted to continue sponsorship of a program for high school coaches before the fall school sport season starts.

Lois Young, MD, reporting for the Professional Education Committee, brought a finalized version of her Committee's program topics for the coming year. Her list represents a distillation of the Committee's proposals and the Directors' editing over the year. Dr. Young indicated the Committee's discomfiture at being overridden and having to revise its scheduled programs more than once.

A Report from the Legislative Committee announced that meetings of the Directors, Committee Chairmen and interested Members with important Legislative leaders would be continued through the coming year at about monthly intervals. Whether BCMS should support the Health Round Table was deferred pending more information about its aims and financing.

Dr. Kassel Elected

A replacement is needed on the Med-Chi Council

for Carol Johns, MD, our representative, who has resigned to go to Wellesley. Leon Kassel, MD, was elected by the Directors from the eight members put in nomination.

Patricia Smith, MD, Chairman of the Health Care Delivery Committee, discussed its thorough and extensive evaluation of the Central Maryland Health Systems Agency's Plan dealing with allotment of hospital beds. Several influencing concepts emerged in the discussion. Dr. Smith noted that over the past several years, although her Committee's analytical comments have not effected any changes in plans that had already been finalized, some of her Committee's ideas have been included in the plans for the years that followed. Complexity of the methodology for determining the number of beds—excess or not—may be faulty. She pointed out, too, that a reduction of a small number of beds may not be cost-effective in that there is basic overhead that is independent of bed count.

Dr. Smith also called attention to the hamstringing aspect of the reimbursement process that must be changed before acute hospitals could also provide associated long-term care. This is not feasible now because of an HSCRC regulation that **ANYTHING** under the roof or aegis of a health care facility must be calculated in the total hospital costs. Separate accounting for endeavors less than acute care, and so less expensive, is not permitted, so, it is not economically possible for hospitals to have the less-costly long-term care wards, yet more long-term care beds are needed and could take beds not utilized for acute—and more costly—care—if the HSCRC permitted separate cost accounting according to need and use. □

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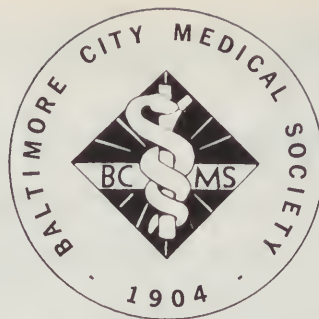
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In Memoriam: A. Austin Pearre, Jr., MD

Former Faculty President Dr. Albert Austin Pearre, Jr., a Frederick physician for more than half a century and member of the old state Board of Health, who was 80 years old, died in his sleep July 21, 1979 at his Frederick home.

During 1943-44, he was President of the Frederick County Medical Society. He was Vice President of the Medical and Chirurgical Faculty also in 1943, and 1950.

A graduate of Boy's High School in Frederick in 1915, Dr. Pearre received his Bachelor's and Medical Degrees at the Univeristy of Virginia.

He served as an intern in Baltimore at the University of Maryland, Church and John Hopkins Hospitals before taking his Residency at Union Memorial Hospital in 1924-25.

He then returned to Frederick to begin a practice that was uninterrupted until 1977, when he retired. In addition to his private practice, specializing in internal medicine and cardiology, Dr. Pearre was physician to Hood College for 40 years.

He also was physician to children and the aged at the Maryland Odd Fellows Home for many years, and to the Maryland School for the Deaf. From 1953-55, he was the Chief of Staff at Frederick Memorial Hospital.

Dr. Pearre was named to the State Board of Health in 1953 by then-Gov. Theodore R. McKeldin. From this forum, Dr. Pearre was among the first to label highway accidents as one of the nation's most serious health problems.



DR. PEARRE

In 1957, he recommended that the State Health Department focus its preventive medicine capabilities on highway deaths instead of such diseases as smallpox, which had ceased to pose a major threat to the public.

He helped organize the Frederick County Heart Association in 1953, and served as its President a decade later. He was a past Vice President of the Maryland Heart Association, which awarded him its Silver Service Recognition Medallion in 1965.

A Fellow of the American College of Physicians since 1928 and a Diplomate of the American Board of Internal Medicine, Dr. Pearre was a long-standing member of the American and Southern Medical Associations and of the Board of Maryland Blue Cross as well.

He was a member of the Frederick Rotary Club for more than 50 years and was the local President in 1940.

He was a member of All Saints Episcopal Church.

Survivors include his wife, the former Eleanor Gould; a son, Dr. A. Austin Pearre, Jr., of Frederick; two daughters, Mrs. William W. Abbot, of Charlottesville, VA and Mrs. Frank Lesure, of Frederick and eight grandchildren.

Speaking in the US Senate, Maryland Senator Charles MC Mathias, Jr. (R.) stated,

"Mrs. Mathias and I were saddened to learn of the death of Dr. A. Austin Pearre of Frederick. Dr. Pearre died peacefully in his sleep last night after a lifetime of service to his friends and neighbors in the community in which he was born and spent his whole life.

"Success" is a word that can be applied to almost every aspect of Dr. Pearre's career. He was chosen by his colleagues as President of the Frederick County Medical Association and later elected President of the Medical and Chirurgical Faculty of Maryland. He was never satisfied with his current level of knowledge and constantly enrolled in courses and programs that advanced his professional skill. 'Success' to a physician does not, however, depend on such material factors, but rather upon the relief he brings to people who suffer the pain and fear of illness.

"By this test, Dr. Pearre would be acclaimed an outstanding success by the thousands he helped restore to health, not only by treating their bodies, but by calming their fears and raising their confidence.

"Dr. Pearre took a long view of his profession. Many years ago, he commented to me that the previous century of medical research had been devoted to the fight against infection, but that the next century would concentrate on body chemistry. As the miracles of medical science have continued to unfold, they have underscored his insight and his accuracy, but with all the recognition that Dr. Pearre received in his profession and for all the advanced training he disciplined himself to absorb, I personally think nothing better can be said of him than that he was the ideal 'family doctor'.

"Our own family experience in benefiting from his skill and kindness is merely an example of many such relationships that made the community so dependent on him.

"When I was a child, my parents took me to see him

for the usual variety of childhood complaints. He was my grandmother's doctor. He helped my father through his last illness and came to his bedside at the time of his death. He continued to be my mother's doctor until his recent retirement and ever since has been on call for her when she needed him. He responded to the crisis in our own lives whenever Mrs. Mathias and I called upon him whether the occasion was childbirth of bee stings, and so I take this moment to bid farewell to Dr. Pearre and to express my appreciation not only for his work, but also for his example. His colleagues in the healing arts will do well to remember the standard of humane service rendered by Dr. A. Austin Pearre to the men, women and children with whom he shared his life.

"Mrs. Mathias and I want to express our sympathy to Mrs. Pearre and to the children and grandchildren who were Dr. Pearre's special pride and joy." □

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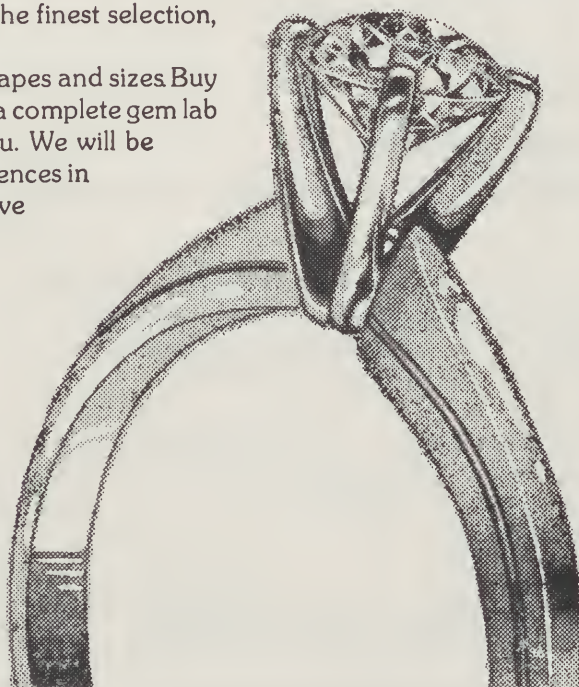
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Maryland Medical Political Action Committee

RICHARD F. MOSCHELL, MD,
Chairman

MRS. AUBREY
C. SMOOT, JR.
Editor

Political Skills Workshop

Wednesday, Nov. 14, 1979

Holiday Inn — BWI

The Chairman and the Board of Directors are delighted to be able to offer to Maryland physicians and their spouses a political skills educational seminar. This was done two years ago with resounding success.

With the oncoming election next year, we must avail ourselves of every resource. AMPAC will provide knowledgeable speakers on each subject. A major topic will be "Practicing Medicine and Politics." Later in the afternoon, there will be a roundtable discussion with some of the Maryland Congressional delegation. They will explain health problems that are unique to their districts. There should be a lively verbal interchange. The afternoon begins at 1 PM and will be climaxed by cocktails and dinner.

The importance of your attendance cannot be too highly stressed. We need now, as always, to be both united and knowledgeable.

Nancy Lee Smoot

Fill Out and Return to

MMPAC — 1211 Cathedral St. — Balt., MD 21201 (301) 539-0872

I wish to make reservations for the Political Action meeting on Wednesday, Nov. 14, 1979, 1 PM at the Holiday Inn, Baltimore/Washington International Airport.

Name

Street

City and State

Telephone

Spouse's Name

Please make _____ reservations for the afternoon plus cocktails and dinner.

Enclosed is my check for \$_____. (\$5 per person)

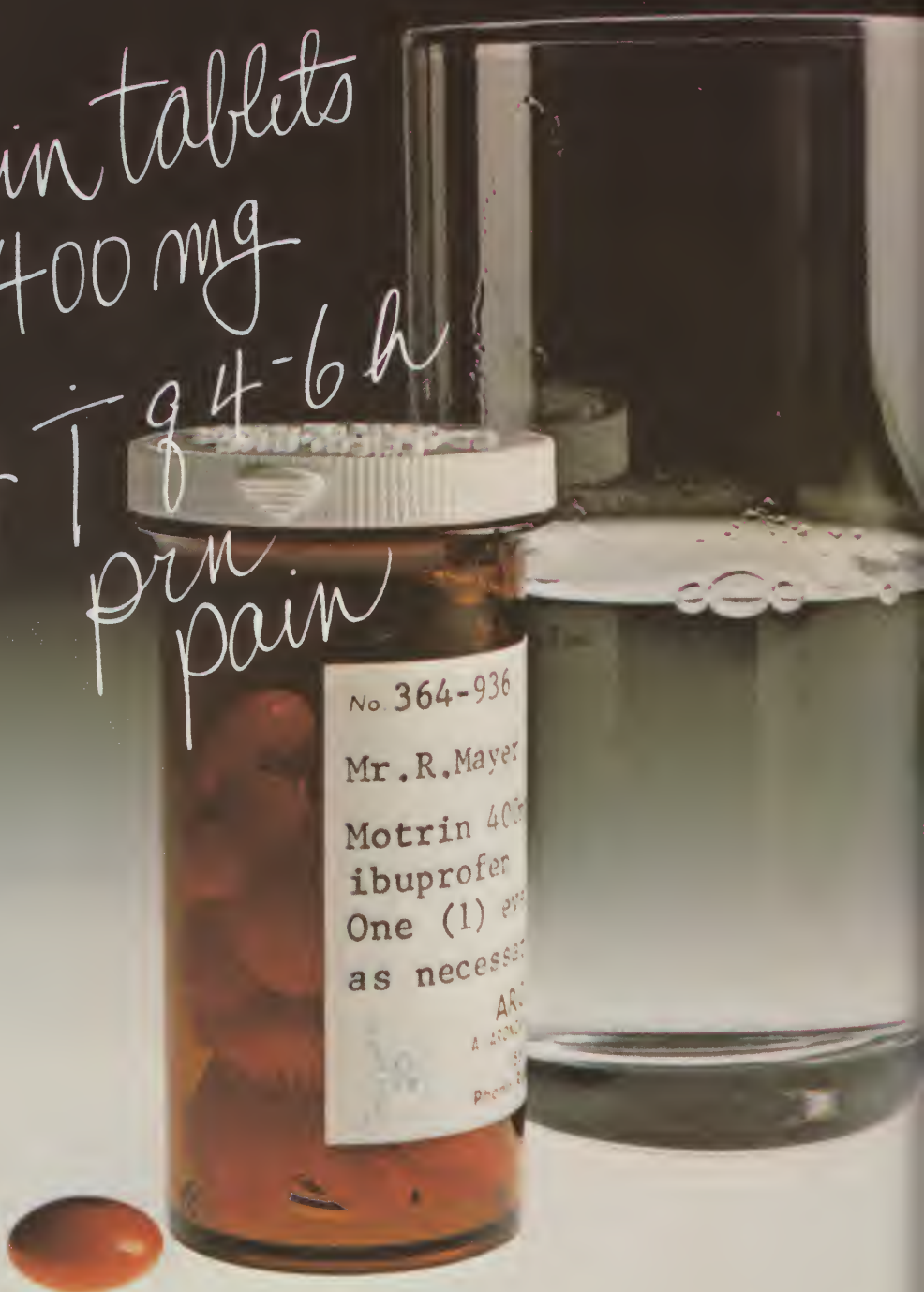
I wish to make _____ reservations for the afternoon session only (no charge)

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	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

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Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400^{TABLETS}mg
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Please turn the page for a brief summary of prescribing information.

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Motrin® (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin: used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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Dr. Guyther *Good Housekeeping's* Family Doctor of the Year

Prominent Med-Chi member J. Roy Guyther, MD, a Maryland physician, was honored at the White House July 18th by First Lady Rosalynn Carter as this year's "Family Doctor of the Year."

Dr. Guyther, 59, who has two children and one grandchild, was received by Mrs. Carter in the Oval Office of the White House. In attendance were six members of Dr. Guyther's family and Dr. W. Jack Stelmach of Kansas City, President of the American Academy of Family Physicians. The AAFP, the national association of family doctors, cosponsors the award with **Good Housekeeping** Magazine, which was represented by Margaret Adams, Senior Editor of national affairs.

Chosen from numerous nominees from AAFP chapters across the country, Dr. Guyther is the third physician to receive the annual **Good Housekeeping** "Family Doctor of the Year" award.

In his letter (full text follows) nominating Dr.

Guyther for the award, C. Earl Hill, MD, President of the Maryland Academy of Family Physicians, described his colleague as: "Gentleman, humanitarian, healer, academician and scholar—this is the theme of Dr. Guyther's life."

A native of and family physician in Mechanicsville, MD, Dr. Guyther was described by Dr. Hill as a "spokesman" for his community, and a "most respected practitioner . . . sought out for advice and counsel by his county, his state, by national organizations and by the Federal government regarding health care."

As a family doctor, Dr. Hill added, "Buck' Guyther assumed total health care responsibility for all the people of his community. He delivered their babies; he cared for the infants and children, the young adults, their family problems and he made a tremendous contribution providing community leadership to make his community a better, happier and healthier place for his patients to live."

A graduate of the University of Maryland School of Medicine in 1943, Dr. Guyther returned to his alma mater in 1972 to serve as an Associate Professor in the University's Department of Family Health. His tenure there, according to Dr. Hill, "Has gained him a reputation among all medical students and residents of real credibility, because he is an ideal, true teaching role model."

A founder of the Family Practice Medical Students' Club, which he still supervises, and the University's Family Practice Department, Dr. Guyther returned to private practice in Mechanicsville in 1973.

Since beginning practice as a family doctor in 1948, Dr. Guyther has delivered more than 1,500 babies.

Good Housekeeping Magazine's new "Family Doctor of the Year" also has served as a Captain in the US Army Medical Corps. He has been President of the Maryland Chapter of the American Academy of Family Physicians and has served as a Delegate from the state to the AAFP Congress of Delegates.

Dr. Pillsbury's Mailgram

"J. Roy Guyther MD
Mechanicsville, MD 20659.

On behalf of your many colleagues and friends in the Faculty, may I express our sincere congratulations on your being named Physician of the Year. Your concern and devotion to patients, as well as your interest in the delivery of high quality medical care, are well-known within the profession. Your selection for this award now brings to public attention your worthiness and outstanding attributes as a family physician and friend.

WILLIAM A. PILLSBURY MD, President
Medical and Chirurgical Faculty of the
State of Maryland."



DR. GUYTHER

(Photo by Tadder, Baltimore, MD.)

Dr. Hill's Letter of Nomination

"Boyd E. McCracken, MD, Chairman
Public Relations Committee
American Academy of Family Physicians
1740 W. 92nd St.
Kansas City, MO 64114.

Dear Dr. McCracken:

The Maryland Academy of Family Physicians submits with pride the nomination of J. Roy Guyther, MD for the 1979 **Good Housekeeping** "Family Doctor of the Year" Award. This nomination is submitted with the complete approval of the entire membership of the Maryland Academy, its Board of Directors and myself, as President and spokesman of the Maryland Academy of Family Physicians.

In your Memorandum of Jan. 5, 1979 requesting nominations, you provided the following quotation as "a guideline for selection:"

"...the Committee will consider all nominations by state chapters; however, because the individual... selected (will) be the subject of national publicity, the committee recommends that nominees... reflect the best characteristics of the family physician, that they... be dynamic, energetic and active members who practice within the precepts of 'care with caring' for the entire family and... demonstrate proficiency in the variety of disciplines of family practice."

Our chapter gave this directive our immediate attention and by means of a rather extensive survey, the name that came up overwhelmingly was that of Dr. J. Roy Guyther of Mechanicsville, MD; however, we had one problem, and that was that your guidelines for nominations paragraph in no way covered the qualities that our candidate has demonstrated. We would like to

paint for you a word picture of the achievements of Dr. Roy "Buck" Guyther.

Born in the small, rural farming community where he learned to live closely with the problems of daily farm community living, he aspired from the onset to be a "family doctor." He received all of his pre-medical, medical and graduate training in the University of Maryland Medical Education System, where he laid the groundwork for his extensive knowledge of medical education and the health care system of Maryland. This was to be an important background for his future activities on behalf of the medical care of the people of Maryland.

Immediately, on completion of his graduate training, Dr. Guyther returned to his home community where he, as a general practitioner, assumed total health care responsibility for all the people of his community. He delivered their babies; he cared for the infants and children; the young adults, the pre-elderly and the elderly. He cared for their injuries, their surgery, their worries, their family problems and he made a tremendous contribution by providing community leadership to make his community a better, happier and healthier place for his patients to live. Because he understood the ways of his people, he became their spokesman, advocate and confidante. He gained a respect from the community and its leadership which made possible the creation of even better conditions for the people of his community.

His concerns for the future of his community, and the wonderful example he set, attracted other family physicians and specialists.

In the early 1950s, Dr. Guyther recognized that the general practitioner of that day needed to be a part of an organized representation. He became a member of the American Academy of General Practice, and was instrumental in the founding of the Maryland Chapter.

From this point on, Dr. Guyther, as a most respected

J. Roy Guyther, MD: "Family Doctor of the Year" Honored at the White House:



Mrs. Rosalynn Carter, representing the President, greeted Dr. J. Roy Guyther of Mechanicsville, MD, July 18th in Washington, DC, on the occasion of Dr. Guyther being chosen *Good Housekeeping's* "Family Doctor of the Year," an award given annually by the magazine in conjunction with the American Academy of Family Physicians. From the left are Mr. and Mrs. Joseph R. Guyther, Jr.; the First Lady; Dr. Guyther; Diedre Elizabeth Logan; Mrs. J. Roy Guyther; Mrs. Kathryn G. Logan, and Academy President W. Jack Stelmach. (Photo from AAFP Reporter, Kansas City, MO.)

practitioner providing the full gamut of general practice in a small community, was sought out for advice and counsel by his county, his state, by national organizations and by the Federal government regarding health care. These requests were for advice, to formulate policies, to propose laws and regulations and to participate in important health care studies.

He was one of the earliest physicians to recommend that the status of the "general practitioner" of the future must be elevated by training, prestige and reward, and, therefore, he was actively involved in the support and establishment of the new specialty of Family Practice. He was most influential in persuading the then practicing general practitioners to recognize that what was important was the future family physician and that this future family physician's quality, training and prestige needed to be enhanced. This was just another example of one of Dr. Guyther's outstanding characteristics, in that while he works hard and effectively in the present, he is always looking ahead to the future of the family physician.

Gentleman, humanitarian, healer, academician and scholar—this is the theme of Dr. Guyther's life.

Dr. Guyther was a charter member of the St. Vincent de Paul Society when it was founded in 1952. During the 27 years since its inception, Roy has provided help to the poor and those struck by sudden tragedy. This has been done by providing food, shelter, clothing and financial assistance in quick response to need. His intimate knowledge of the problems of those living in his community has been and continues to be invaluable. In the work of the St. Vincent de Paul Society, families with homes ravaged by fire, husbands suffering from unexpected unemployment, farmers feeling the anguish of a disappointing harvest and the young and old living in the isolation of the chronically ill, have all been touched by his work. Dr. Guyther has given this help for over a quarter of a century freely, consistently, compassionately and without public recognition.

St. Mary's County was the first county in Southern Maryland to have a first-rate nursing home. Dr. Guyther spearheaded these efforts and has served as Medical Director of the St. Mary's Nursing Home since it was established in 1965. During this time, it has proved to be an excellent health care facility. Many bed-bound patients whose families could not care for them at home have had their health restored at the Nursing Home to a degree that has permitted them to live as an independent family member once more. Many old and incurably-ill patients have died with dignity there. St. Mary's Nursing Home is a most valued facility in St. Mary's County and Dr. Guyther's efforts, more than any other individual, have made it so.

He is a physician who, in the time of need for teachers in the discipline of Family Practice, left his practice to return to his alma mater to give others the benefit of practice experience. This would become one of the oldest medical school Departments of Family Medicine. At the University, he demonstrated his skill as a teacher. His scholarly and academic approach, but, most of all, his practice background gained him the reputation from all medical students and residents of real credibility, because he was an ideal, true teaching role model. This phase began in 1967—two years before

the specialty of Family Practice was founded. He was also instrumental in founding the country's first Family Practice Medical Students' Club, which he still supervises. When his University's Family Practice Department was well established, he returned to his practice.

There is another outstanding contribution of Dr. Guyther that requires special attention. This has been his special ability to bring together the older general practitioners who were the time-honored traditional practice foundation, with the current medical students, residents in training and new family physicians. Since 1952, in his State Chapter, and since 1963 as a Delegate in the House of Delegates of the American Academy of Family Physicians, he has over and over again been able to have each of these groups appreciate the values of the other, so that they came out working for the common good of the future of family practice. In the evolution of family practice as a new discipline, his ability to bring the old and the new together has been most fundamentally responsible for the advancement of family practice. Many a time in the House of Delegates it was Dr. Guyther's reassuring common sense that calmed serious potential diverse situations. The respect that he has gained as a 16-year Delegate in the House has brought many of the Academy leaders to seek his advice and counsel.

Dr. Edward J. Kowalewski, a Past President of the American Academy of General Practice, and currently the Chairman of the Department of Family Medicine at the University of Maryland, has probably best identified Dr. Guyther's contributions as follows:

'The strength of accomplishment of J. Roy Guyther emanates from the fact that he is a complete family physician who is doing his job daily for his patients and his community. He epitomizes the true family physician role model that the people of our country holds in such high esteem. He is an example of the spirit and service that must be preserved if family practice is to continue its respected position.

Many family physicians have contributed much to their communities, but not many have had the dedication, ability, talent, personality and willingness to translate their deep-rooted foundations of the principles of general practice into the teaching of the family physician of the future. In my opinion, a very large part of the success of the family practice movement to date and the measure of progress for the future must be attributed to just a limited few who can project such a true role model to trainees. Dr. Guyther is the most effective contributor I have seen in this role.

I must make one more important comment about Dr. Guyther from my position as Chairman of a University Department of Family Medicine. Those of use who are Chairmen fully recognize that we could make very little progress without the support and encouragement, advice and guidance of respected behind-the-scenes worker who is always there to give that important support so frequently needed.

I would like to summarize my feelings about Dr. Guyther by saying with all the conviction and sincerity I can muster that Family Medicine, clinically and academically, is where it is today in our state because of the efforts of Dr. J. Roy Guyther. Because of this, he should receive all of the recognition he truly deserves.'

The citizens of St. Mary's County and of Mechanicsville are most eager to honor their "family doctor," Dr. J. Roy Guyther. They have provided all sorts of documentation and testimonials in support of his nomination for the "Doctor of the Year" award. They are prepared individually and collectively to appear before any forum to attest to his value to their community.

The Maryland Academy of Family Physicians is therefore most pleased to certify all of the accomplishments of Dr. J. Roy Guyther mentioned above, and is therefore proud to nominate him for this most prestigious award. We also feel that Dr. Guyther's achievements are unique in that they not only include the traditional complete family practice service accomplishments, but also important teaching and scholarly activities that have been most exemplary and most outstanding.

As President of the Maryland Academy of Family Physicians, I am prepared to provide any additional documentation that you may require in support of our candidate.

C. EARL HILL, MD

President
Maryland Academy of Family Physicians

Curriculum Vitae: Joseph Roy Guyther, MD

Born

July 31, 1920
Mechanicsville, MD

Residence

Rt. 3, Box 272
Mechanicsville, MD 20659
Telephone: (301) 884-3148

Family

Married — Elizabeth Tyrie, RN
Cockeysville, MD, 1943
Children — Son, Joseph R.; Daughter, Kathryn T. Logan; One granddaughter

Personal

Private Practice: 1948-73 — Mechanicsville, MD
Full-time Faculty Position — University of Maryland, Family Practice Program 1972-73.
Resumed Family Practice, Mechanicsville — 1973.
Part time Faculty Position — Department of Family Medicine, University of Maryland
Director of Preceptorship Program

Education

Attended Charlotte Hall Military Academy 1933-37
Class Valedictorian
Medical School — University of Maryland School of Medicine, Graduated December, 1943
Internship — Mercy Hospital, Baltimore, MD, 1944
Residency in Medicine, Mercy Hospital, Baltimore, MD, 1946

Military

United States Army
Captain, Medical Corps, AHS 1946-48

Licensure

State of Maryland, 1943

Board Certification

American Board of Family Practice, 1971, Recertified, 1977

Academic Appointments

Associate Professor, Department of Family Medicine, University of Maryland School of Medicine;
Joint Appointment, Department of Preventive Medicine and Epidemiology, University of Maryland School of Medicine Combined Research associated with Family Medicine

Hospital Appointments

St. Mary's Hospital, Leonardtown, MD, 1948-present, Chief of Staff 1956-58
Medical Director, St. Mary's Nursing Home 1965-present
University Hospital, Department of Family Medicine, Baltimore, MD

American Academy of Family Physicians

Enrolled, 1952; Fellow, 1972
Maryland Chapter Offices: President, Board of Directors, Delegate 1963-present
AAFP Committees: Tellers Committee, 1964
Reference Committee Reports of Officers and Committees, 1966
Reference Committee Constitution Bylaws, 1973
Scientific Program Committee 1970-73
Commission on Environmental and Public Health 1974-77

Membership in Medical Organizations

American Medical Association 1948-present
Society of Teachers of Family Medicine 1970-present

Membership in Other Medical Organizations

St. Mary's County Medical Society 1948-present
Medical and Chirurgical Faculty of State of Maryland 1948-present
Council, Medical and Chirurgical Faculty 1960-66
Council on Medical Care, State of Maryland 1958-67
Medical Assistance Advisory Council, State of Maryland 1967-69
Governor's Commission to Study Shortage of General Practitioners 1965
Subcommittee, Review Financing of Maryland's Medical and Hospital Programs 1960
Health Manpower Committee, Advisory Council for Higher Education 1967-68
President's Commission on Employment of Handicapped 1967-present
Heart Association, Southern Maryland, Board of Directors 1956-59
State Board of Medical Examiners of Maryland 1969-present

Community Services

Chairman, Parish Council, Immaculate Conception Church
Member Archdiocesan Pastoral Council
Lions Club of Mechanicsville — Past President
Knights of Columbus
Member — Welfare Board of St. Mary's County
St. Vincent de Paul Society
Immaculate Conception Conference

Practice Narrative

J. Roy Guyther, MD began private solo practice on Jan. 1, 1948 in Mechanicsville, MD, population 250, as one of eight practicing physicians in the whole of St. Mary's County (population 35,000). Because one of the physicians in the county was impaired and four were over 70 years of age, the area was medically underserved and Dr. Guyther became dedicated to encouraging additional physicians to locate in St. Mary's. After seven years of solo activity, he added a series of associates in his practice. A total of five young physicians and one dentist were provided office space. Indirectly, with equipment and financial inducements to begin medical practice, he was responsible for two surgeons establishing practices in the area. At the same time, he became involved in the same activity of recruiting physicians on a statewide basis.

Dr. Guyther became actively involved in the establishment of a nursing home for St. Mary's County. After four years as Chairman of a planning committee and two years of advice on construction, the St. Mary's Nursing Home was completed and Dr. Guyther has served as Medical Director since its dedication in 1966.

During his years of medical practice, Dr. Guyther has delivered approximately 1,500 babies. This service has extended into the second generation, i.e., delivering mothers whom he had delivered.

Dr. Guyther has regularly made house calls since beginning medical practice in 1948. He continues to provide this service on every working day.

Dr. Guyther has spent thousands of hours in the past 30 years on committees involved in medical and civic affairs on the state and local levels.

Publications

Dicumarol in Acute Coronary Thrombosis, H. Raymond Peter, MD, J. Roy Guyther, MD and Charles E. Brambel, PhD; JAMA, 130:398, 1946.

Metastatic Cancer Simulating the Guillain Barre Syndrome, Bulletin of the School of Medicine University of Maryland, Vol. 30, No. 3, October, 1945.

The Challenge of Rural Practice. General Practice, Vol. XII, No. 2:82, August, 1955.

The Patient's Right to Privacy and the Students Need to Know. The New Physician, August, 1974.

The Right to Die. Maryland State Medical Journal, June, 1973.

New Concepts of Rocky Mountain Spotted Fever, Clinical Medicine, September, 1974.

The Challenge of Rural Practice (Reprinted). Clinical Medicine, 83:23-27, May, 1976.

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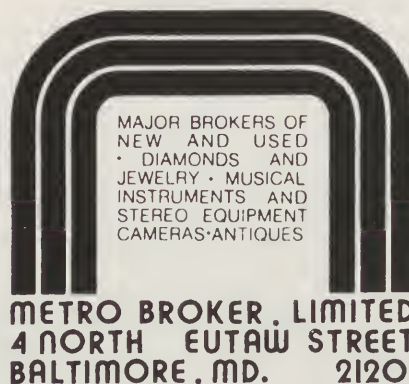
(See page 40 for article by Dr. Guyther, Medical Attitudes of the Amish.) □

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Medical Attitudes of the Amish

By J. Roy Guyther, MD, ABFP

For reprint and other data, write Dr. Guyther at Rt. 3, Box 272, Mechanicsville, MD 20659.

The Amish are a conservative Christian group in North America who are primarily members of the Old Order Amish Mennonite Church. The religious sect originated in Europe by way of a schism in The Mennonite Church in Switzerland, Alsace and South Germany. Jakob Ammann, the leader of the church group, taught that members should dress in a uniform manner, that beards should not be trimmed and advocated the practice of shunning those who violate the precepts of the faith.

The Amish began migrating to North America around 1720 and first settled in eastern Pennsylvania. At present, there are groups in approximately 20 states. The Old Order Amish are best-known for their severely plain clothes, and non-conformist way of life. This cultural non-conformity is considered by the Amish to be based on Biblical strictures, but it also represents a continuance of 17th Century European rural customs. The Amish shun telephones, electricity and drive horses and buggies rather than automobiles. They cultivate the land without the use of modern farm implements. There are an estimated 60-70,000 Amish in the United States.

Because marriages with non-Amish are strictly forbidden and because their mobility is limited, there is a high degree of consanguinity in the group. Their closed society, together with their limited number of ancestors, has maintained a population which in turn has proved to be a valuable source for human genetic studies.

Thirty years of medical practice in a community with a large Amish population has provided an opportunity to analyze certain characteristic attitudes which these hard-working, frugal people exhibit.

The individuals in the Amish sect say they are no different than the average person; However, their strong religious beliefs and their nonconforming life-style made this contention difficult to support. They do have a strong faith in the will of God. Because of this they do not subscribe readily to the concept of insurance, as this suggests that should things go badly there is a hedging of the risk, or entering into a transaction that will protect against loss and thus a willful interference with the divine plan. Somehow such an action might indicate a lack of faith that things will go well for those who deserve it. Reticence about the insurance concept has caused troubles to the Amish with regard to Social Security payments. At least one Amish farmer had his horses seized for failure to pay Social Security taxes. The Amish do not buy life insurance, and they do not buy hospital and medical insurance such as Blue Cross and Blue Shield. This is perceived as betting against the odds of becoming ill and needing hospitalization or expensive physician fees. The community comes to the aid of the hardship cases who have unusual medical expenses beyond their ability to pay, hence the pressure

is off the individual to provide for an unforeseen catastrophe.

As a group, the Amish have a higher birthrate than the average in the US with the typical couple having seven children. Though they appreciate the need for good medical care, they often seek ways to avoid high costs. The lack of hospital insurance has prompted many to seek obstetrical care from midwives and to favor home deliveries partly as a cost-saving action and also because they recognize that modern hospital practice intrudes into family life. Now that modern medical practice has virtually eliminated the granny midwife, the Amish are turning to nurse midwives for home delivery. They are willing to accept the added risks for the sake of economy and personal satisfaction.

Out-of-hospital deliveries may seem fiscally sound, but there is a definite sacrifice of safety. There are statistics available from a number of states substantiating the fact that there are significantly more still births and other perinatal mortality from out-of-hospital deliveries when compared to in-hospital. Therefore, because of economic factors and because of a feeling that modern medical technology applied at the time of delivery is interference with the family, the Amish expose themselves to a higher risk of perinatal complications than is ideal.

The Amish have not yet accepted the philosophy of preventive medicine. Their medical care is episodic i.e., when a problem presents itself, medical advice or service is sought, but it is very unlikely that any Amish, be he farmer or bishop of the community, would present himself at his physician's office for an annual physical. This philosophy carries over into other preventive medicine measures. Very few of the children in the group in Maryland receive routine immunizations. Only after an outbreak of whooping cough could the family physician prevail upon the Amish to have their children immunized against this serious childhood infection. There is no religious prohibition against immunization procedures. Since the public health authorities will provide immunizations at no cost, there are no economic barriers. The reasons for not seeking this protection could only lie in tradition or in the concept that immunizations are similar to insurance. It is perceived that one may be lacking in the faith that God will protect, and consequently is hedging his bet that the child will not contract a serious communicable disease.

There is a very slowly developing trend for young married couples to accept immunizations of their children. An unusual case of vaccine-associated poliomyelitis has set back this trend in the Southern Maryland Amish Community. The low level of naturally occurring immunity among the unvaccinated in this closed community resulted in paralytic polio in a young mother who was a contact with four infants who received oral trivalent polio vaccine.

Case Report

A previously well 27-year-old woman from an

Amish community in Southern Maryland complained of pain in her right shoulder. The patient thought she had injured her shoulder in helping with tobacco farming and consulted a chiropractor in a neighboring town. When the patient was seen by a local physician approximately one week after onset of her symptoms, she complained of weakness, headache and continued pain in the right shoulder.

Examination revealed oral temperature of 38°. There was no skin rash. She exhibited the classic tripod sign when attempting to sit up on the examining table. There was resistance to flexion of her neck, but frank nuchal rigidity was absent. There was motor weakness of the right upper extremity with absent sensory signs. The remainder of the physical examination was not significant except that the patient was approximately 15 weeks pregnant. Lumbar puncture revealed 118 w.b.c., 97% lymphocytes, 1% monocytes, 2% polymorphonuclear leukocytes. White blood count 6,200 with a normal differential. Electrolytes, renal function and liver function were normal.

There had been documented exposure to several small children who had recently received trivalent oral polio vaccine. A stool culture yielded poliovirus, type 3, vaccine-like antigenically with a positive temperature marker at 39.9 C.

One year after onset, the patient continues to have weakness that has resulted in impaired function of her right arm. She delivered at term of a healthy female child.

Twenty one persons, most of whom were associated with the case of poliomyelitis, submitted sera to be screened for the presence of antibody against poliovirus; 14% were immune to Type I, 86% to Type II and 67% immune to Type III.

The above data, the documented exposure of the patient's children and the patient to recent vaccines and the antigenic and temperature characteristics of the isolate support the hypothesis that this was a case of community contact vaccine associated poliomyelitis.

Since this case occurred, the other parents in the Amish community have been more resistant to routine immunization of their children.

There is one further characteristic of the Amish that has been observed, but is difficult to document. There is an inclination for these people to seek the services of medical cultists such as naturopaths, chiropractors and other unorthodox healers. The desire for personal attention, and the satisfaction achieved from a healer by physical manipulation may well be the underlying basis for this propensity of turning to non-medical practitioners. Religious persecution which the Amish were subjected to in Europe may well have created a somewhat distrustful feeling toward the matter-of-fact, scientific approach of modern medicine.

How do these medical attitudes of the Amish affect their health? First, the lack of medical insurance tends to cause the individual to delay medical attention until a problem becomes urgent.

The failure of the Amish to seek preventive medicine measures likewise tends to delay care for some illnesses. This is true not only of primary preventive measures such as immunizations, but secondary meas-

ures which might assist in early detection of disease and also tertiary prevention, which aids in minimizing physical damage produced by disease processes. The Amish definitely tend to seek episodic care for their medical problems, rather than continuing care. In other words, when they feel well they feel no need for a physician; when they feel ill, they seek medical services.

The added risk of out-of-hospital deliveries has previously been alluded to. The decisions for this type service are based on the feeling that modern medical hospital technology interferes with family life. Individual families make their own decisions, but the pervasive burden of cost influences these decisions.

The perception that the Amish as a group are inclined to seek non-medical practitioners for relief of their ills has not influenced their overall health, morbidity or mortality. The natural course and outcome of many diseases is not always determined by medical intervention. If the failure to obtain quality medical care were the only determining factor in outcome of disease, the Christian Science sect would have been decimated years ago. The human organism has a self-corrective ability, and sophisticated medical care offers only the extra 10-15% chance of improving the overall outcome of ill-health.

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W. Michael Gould, MD

Chief, Division of Dermatology
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Associate Director Department of Obstetrics and
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11:15 AM Prevention of Sports Injuries

Lawrence Blumberg, MD

Noon Luncheon — Informal discussion

1 PM The Grieving Patient (Preventive Aspects)

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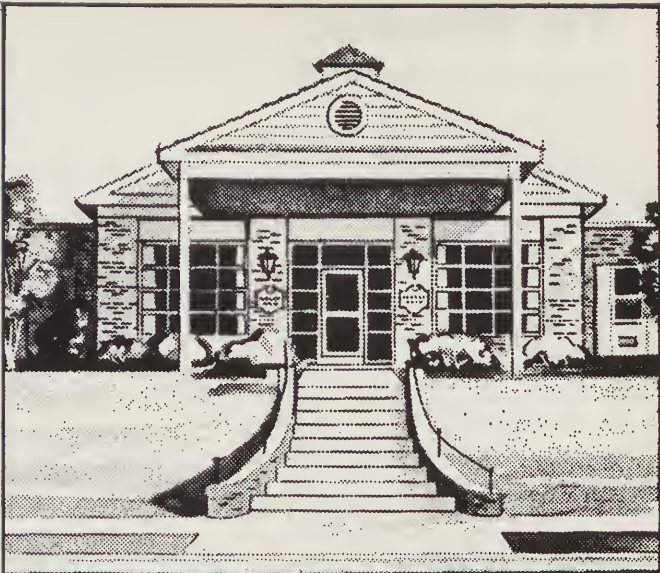
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Fat Embolus

By TIMOTHY A. LAMPHIER, MD.

For reprint and other data, contact the author at 117 Aliso Dr., Palm Springs, CA 92262.

Fat Embolism is one of the most serious complications of trauma and it bears a strong similarity to such complications as congestive atelectasis, respiratory distress syndrome and shock lung. Automobile accidents resulting in multiple long bone fractures have made Emergency Room physicians and surgical consultants more cognizant of this condition with its attendant mortality and morbidity. Fractures with fat emboli will run mortality rates as high as 5% in fractures of the tibia, 10% for femoral fractures, and 20% for combined fractures of both the femur and tibia.¹

Fat Embolism occurs in 1 or 2% of all patients with fractured femur or tibia shafts and of this group the death rate will be 20 or 30%.²

Such conditions as extensive injuries to soft tissues (without fractures), Sick Cell Anemia, Diabetes, acute hemorrhagic pancreatitis and chronic alcoholism can also be accompanied by fat embolism.

Pathophysiology

The source of fat emboli consist mostly of neutral fat. Fat cells ruptured by trauma release fat droplets which enter the venous drainage at the local sites of injury. These droplets are trapped as emboli in the lung filters having passed through pulmonary arteries. It is the systemic fat emboli that are responsible for fat found in urine and possibly is the basis for formation of characteristic petechiae. Also, biologically active substances, such as plasmakinins, may reach the systemic circulation from injury sites.

It is a medical fact that particulate matter released into the venous circulation produces signs and symptoms of acute "Cor Pulmonale" by raising pressure in the pulmonary arterial system and right atrium. Vasoactive amines released from lung parenchyma cells

produces vasospasm and airway constriction. The lungs normally contain large numbers of platelets.

In addition to the lung containing large numbers of platelets, there is always clumping (or aggregation) of platelets following trauma. Droplets of fat become coated with a thin layer of platelets in their passage to the lung or after their arrival in the lung. Large numbers of platelets will then sequester and break down in the lung releasing a humeral factor, especially Serotonin via platelet amines. The release of 5-HYDROXYTRYPTAMINE (5-HT) causes broncho-constriction and pulmonary venous constriction and ultimately passive congestion of the pulmonary capillary bed. The pulmonary alveolar surfaces are composed of Type 1 pneumocytes and occasional Type 2 pneumocytes. The functions of the Type 1 pneumocytes are not well understood except that they are involved in the clearing mechanism of the lung. However, the Type 2 pneumocytes produce lung surfactant which lines the alveoli as an extra cellular layer of fluid of phospholipid material lying on top of a base of protein material. Plasma colloid osmotic pressure and lung surfactant oppose the movement of fluids from capillaries into alveoli.

These pneumocytes promote hydrolysis of neutral fat droplets to glycerol and free fatty acids. Free fatty acids from systemic depots are produced secondary to the release of catecholamines. Trioleic and Oleic acid cause an immediate loss of surfactant material and subsequent thickening and marked vesiculation of the alveolar and capillary wall. Hemorrhage, edema and atelectasis result with characteristically severe arterial hypoxia occurring.

Symptoms

Clinical Features: The characteristic triad of symptoms are:

- | | |
|--------------|---------|
| a. Pulmonary | } Triad |
| b. Cerebral | |
| c. Petechiae | |

A. Pulmonary:

1. Respiratory distress.
2. Tachypnea with rales (30/min. or higher).
3. Hemoptysis.

4. Diffuse rhonchi and rales.

5. ??? Pleural friction rubs.

B. Cerebral (Prognosis is poor)

1. Mental confusion
2. Comatose
3. Drowsiness
4. Restlessness
5. Obstreperousness
6. Cerebral Ischemia
7. Headaches
8. Apprehension
9. Stupor
10. Convulsions
11. Cortical Blindness
12. Hemiballismus

C. Petechiae in axillae, chest, root of neck, subconjunctival areas and soft palate occur on the second or third day and are present in over 80% of patients.

Diagnosis

A. Carry out on a daily basis, the following **three tests for the presence of fat**:

1. **Urine** — (the urine is positive for fat³ in 50% of cases).
 - a. Collect 24 hour specimens of urine in a grease-free collecting flask.
 - b. To 15 cc. of urine in a centrifuge add five drops of oil red stain or Sudan iii or Sudan iv (Sizzle Test of Scuderi).
 - c. Chill for one hour.
 - d. Centrifuge up to 2000 rpm for five min.
 - e. With Capillary pipette or wire loop, transfer sample from very top of supernate to free-fat microscope slide.
 - f. In Nembauer chamber obtain count of red stain bodies — (neutral fat appears as irregular masses of bright red material).
 - g. As a control, run known negative urine and a saline solution made positive by the addition of some bone marrow.
2. **Blood** — Venous from injured extremity or via Swan-Ganz Catheter.
 - a. Centrifuge 10 cc. of venous blood in EDTA at 3,000 rpm for 15 minutes.
 - b. Using white cell pipette, draw very top

of plasma to mark 1, then oil red stain — (2 gm. oil red powder, 50 cc. acetone, 50 cc. 30% alcohol, 1 cc. concentrated acetic acid) — to mark two.

- c. Shake pipette for five minutes.
- d. Wipe two Neubauer counting chambers with Xylene, fill and let stand for two minutes.
- e. Count red-stained globules in all nine squares of both chambers.
- f. To calculate fat particles per cubic millimeter multiply total count by 10 and divide by 1.8.

3. Sputum

- a. Prepare thick sputum smear with wire loop on degreased microscope slide.
- b. Stain for neutral fat according to standard AFIP technique.
- c. Examine under microscope for microscopic fat globules — "They are extracellular and are 10-40 μ in diameter."

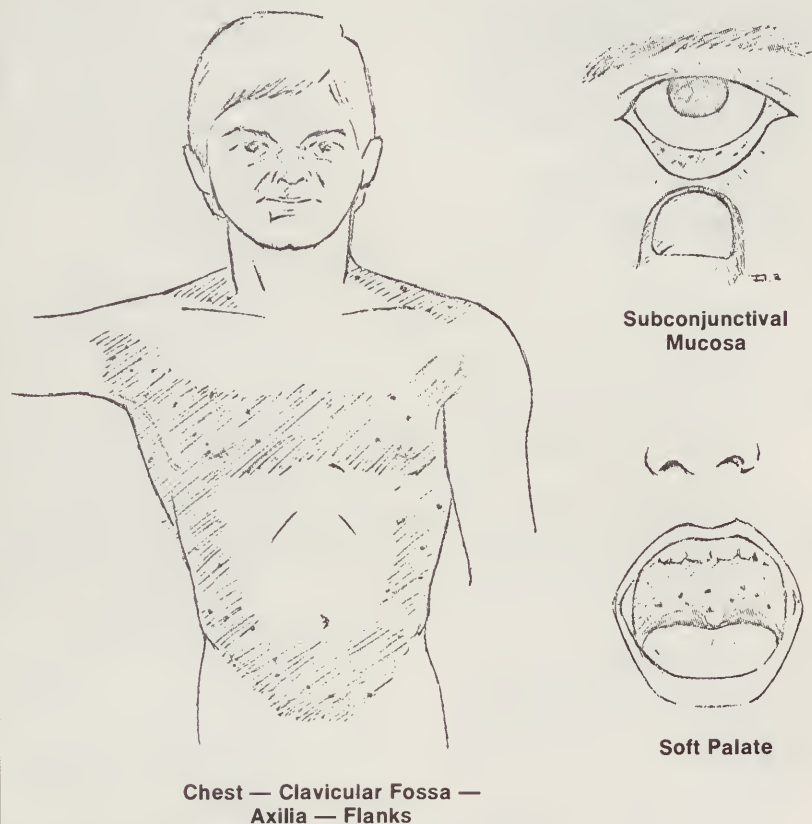
4. **Serial Thoracic Roetgenogram** daily (using original as baseline, check for diffuse infiltration or snow storm-like appearance). (These are **positive in only a small percentage** of cases).

5. **Daily Fundoscopic Examination** (for intravascular fat) and also hemorrhage in vitreous.

6. Daily Laboratory:

- a. Hematocrit and hemoglobin (watch for sudden drop).
- b. Prothrombin.
- c. Platelet count (thrombocytopenia occurs).
- d. Serum calcium (may be decreased due to interaction of calcium and fatty acids).
- e. Urinalysis (free fat in 50%).
- f. BCP₁₆
- g. Serum lipase (rises on third-fifth post-injury day).

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- h. Cross match and keep in reserve four units of whole blood.
- 7. **Serum Haptoglobin**
- 8. **Daily Vectorcardiograms** is the best method of detecting cardiac abnormalities accompanying fat embolism. **Check for:**
 - a. Right Heart Strain.
 - b. Tachycardia.
 - c. Arrhythmias (Sudden appearance of prominent "S" waves in lead I).
 - d. Prominent Q waves in lead two.
 - e. Inversion of T waves.
 - f. Shift of transient zone to the left.
 - g. Depression RST segments.
 - h. Right Bundle Branch Block.

Treatment

1. Monitor four times daily arterial blood gases for at least three days for hypoxia.
 - a. pO_2 , pCO_2 , and pH may be low.
 - b. Cryostat frozen section of blood in every case that paO_2 is less than 60 mm. of mercury. Keep paO_2 at 70 mm. Hg.
 - c. Earliest parameter to respond is pO_2 (12-24 hours).
 - d. The objective is to maintain the arterial pO_2 between 60-80 mm. Hg.
 - e. When an arterial pO_2 of more than 60 mm. Hg. cannot be maintained by the administration of 40% oxygen in a tent, intubation or tracheostomy should be carried out. Volume respirator is much more satisfactory.
2. Monitor the following: Temperature, Pulse, respiration and blood pressure every four hours. (Frequently temperature is over 102 degrees F. and cardiac rate is 115-130).
3. Maintain CVP (Central Venous Pressure). Never allow over 20-25 cm. H_2O .
4. Oxygen and aminophyllin for wheezing (oxygen mask 10-15 liters per minute with humidity). A volume respirator is superior to a pressure respirator. Keep pO_2 between 60-80 millimeters of mercury. Arterial pO_2 never over 100 mm. Hg. because O_2 then becomes toxic.
5. Positive and expiratory pressure (PEEP) is required to improve the respiratory status of the patient.
 - a. Once the adult respiratory distress syndrome occurs, the only treatment that has been shown to be effective is mechanical ventilation with positive end expiratory pressure.
 - b. PEEP should be instituted if an arterial pO_2 of greater than 75 mm. Hg. cannot be maintained with an inspired oxygen concentration of less than 50%.
6. Tracheostomy with positive-pressure Ventilator.
 - a. Following intubation and placement of the patient on a volume cycled respirator, measurements of cardiopulmonary dynamics are performed.
 - b. Early and repeated measurements of the arterial blood gases and pH have become the cornerstone of both the diagnosis and the management of patients with fat embolism.
7. Morphine grains 1/8 or 1/4 for restlessness, pulmonary hypertension and prior to bronchoscopy.
8. Digitalis for right ventricular failure (Cor Pulmonale).
9. Alcohol intravenously: ... (Controversial)
 - a. 1000 cc of 5% dextrose with 5% ethanol solution intravenously every 12 hours for three-five days.
- b. Also ethanol orally for the first four to five days. (Ethanol is a vasodilator, lipase inhibitor and ??? detergent.
10. Heparin 20-50 mg. every six-eight hours (it is Lipolytic and prevents aggregation of platelets). ... (Controversial treatment).
11. Steroids:
 - a. 125 mg. of Solu-Medrol intravenously stat.
 - b. 100 mg. every four hours for three days. (Or Solu-Cortef 600-1,200 mg. in 24 hours). (Reduces edema and diapedesis of red blood cells in lungs).
12. Biopsy petechiae for intravascular fat. (Petechiae secondary to thrombocytopenia).
13. Routine treatment of shock if present with IV fluids, etc., starting with Ringer's Lactate.
14. Glucose prevents fat embolization:
 - a. Fifty milliliters of 50% glucose solution is injected intravenously during a one to two minute period on a four hour schedule for three consecutive days.
 - b. The hypertonic glucose therapy produces a decrease in serum cholesterol, triglycerides, total lipids and free fatty acids.
15. Dextran "40" - 500 cc. intravenously every 12 hours (to reduce aggregation of red blood cells).
16. Preventative program to offset GI bleeding.
 - a. Milk
 - b. Antacids
 - c. Anticholinergics
 - d. Cimetidine
17. If indwelling catheter to monitor urinary output is desired, use a three-way Foley with Neosporin GU Irrigant.
18. Atromid-S (Clofibrate) tabs 1 t.i.d. (to reduce blood lipids and reduce adhesiveness of platelets).
19. IPPB every three hours

with 80% oxygen and 30% ethyl alcohol.

20. Diuretics - 50 mg. Edacrin I.V.
21. Aminophylline - 250 mg. - IV (**Slowly**).

•

The following table represents a possible pathogenesis of respiratory distress following Fat Embolism

Fracture
Fat Emboli
Lungs
Pneumocytes
Time Lag
Fat
Free Fatty Acids
Lipase
Endothelial Damage
Pulmonary Congestion
Decreased Pulmonary Compliance
Hypoxia-Acidosis

Dr. Robert E. Dutton of Albany Medical School recently reported great success using a Swan-Ganz Catheter for sampling the pulmonary microcirculation and extracting and staining macroglubules of fat it may contain.

"If fat is found, these patients are placed on mechanical ventilatory support before a high shunt and high V_D/V_T develop. If fat emboli escape through arteriovenous shunts into the systemic circulation, peripheral capillaries in the brain, skin, and kidneys may be occluded."⁴

Summary

There has been presented a description of the pathophysiology and importance of the immediate recognition of fat embolism. Once diagnosed properly, only 70% survive. The Triad of symptoms are outlined. Most important is proper treatment of pulmonary pathology and pulmonary distress. The severity of the condition is related directly to the duration and degree of hypovolemia and shock. A Systolic Blood Pressure of less than 100 mm. of mercury (Hypotension) and a cardiac rate greater than 120 per minute often doubles the mortality rate.

Criteria for the Laboratory

Diagnosis of Fat Embolism: (Helpful in pinpointing the clinical entity).

1. Lipuria—Lipemia
2. Elevation of the serum lipase.
3. Chest X-ray
4. Electrocardiogram
5. Thrombocytopenia
6. Decreased arterial pO_2 .

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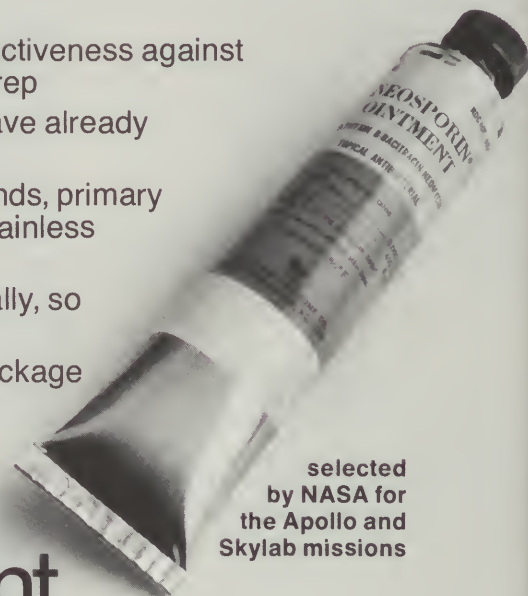
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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The Role of the Speech Pathologist in Treating the Dysphonic Patient

By LINDA E. SPENCER, PhD

Dr. Spencer is Assistant Professor of Speech Pathology in the Department of Speech at Baltimore's Loyola College, where she can be contacted for reprint and other data.

Introduction

"The majority of voice disorders are the result of **abuse** and **misuse** of the vocal mechanism."¹ These disorders include such pathologic entities as vocal nodules, polyps, contact ulcer and granuloma, polypoid degeneration, as well as reddening, thickening and bowing of the folds. Frequently, successful treatment of the voice-disordered patient requires the close interaction of the laryngologist and the speech pathologist to prevent the recurrence of the original lesion and to promote improved vocal use. The purpose of this article is to describe vocal abuse as a causative agent in dysphonia and to acquaint the reader with techniques used by speech pathologists to restore vocal function.

Understanding Vocal Abuse

It is important to understand that there are many sources of vocal abuse. Perhaps most obvious is the screaming and yelling characteristic of preadolescent boys while playing competitive games. Among factory workers, noisy workplaces encourage elevated speaking levels, while adding mechanical or chemical irritation to the vocal folds from airborne dust or other agents. Business and professional people who rely on their voices for their livelihoods are susceptible to vocal abuse as well. Stress associated with a high need to achieve, which is characteristic of many of these people, underlies some of the voice problems which they experience. Careful listening suggests that many successful businessmen use high levels of muscular tension in the laryngeal area to produce a highly controlled, authoritative-sounding voice. Almost invariably, they report that they never speak above a normal conversational intensity.

Tissue changes which occur with vocal hyperfunction are usually accompanied by perceptible alterations in the vocal tone which are easily recognized by the experienced clinician. Some voice changes have etiologic significance, while others reflect the extent of the lesion. Disorders of voicing which should be recognized include the following:

1. Vocal roughness corresponds to hoarseness or harshness. The degree of roughness is closely related to the size of a space-occupying lesion located on the vocal folds, although it can be readily imitated by someone with a normal larynx.²
2. Pitch breaks are abrupt involuntary shifts of the voice to higher or lower pitches and may suggest the degree to which fine control of the internal tension of the vocal folds has been lost.
3. Phonation breaks are abrupt, involuntary cessations of phonation, due perhaps to the interfer-

ence of a lesion, or simply to an inefficient habitual mode of phonation.

4. Inappropriately low pitch is heard more often than high pitch. It can have etiologic significance, as when it is used habitually by those who wish to sound more authoritative. In addition, increased mass of the vocal folds, as when they are edematous, may lower the pitch of the voice.
5. Glottal shock is an abrupt form of vocal initiation which gives emphasis to words beginning with vowels. Used excessively, especially in conjunction with laryngeal tension or pitch lowering, it can be extremely abusive.

These alterations in the vocal tone are usually accompanied by such subjective feelings as discomfort, tightness or pain in the laryngeal area, a feeling of a foreign body being in the laryngeal or sublaryngeal area, loss of speaking intensity toward the end of the day, and loss of the upper pitches in the singing range. Frequently, the patient is more concerned about the throat discomfort than the vocal quality change.

Management

The goal of effective management of the dysphonic patient is to restore the voice to normal function if at all possible. The first step is to establish baseline data documenting the physiologic and perceptual state of the vocal mechanism. This is accomplished during the initial evaluations by the laryngologist and the speech pathologist. The initial medical evaluation of the larynx documents the appearance, size and location of any lesion before intervention has been initiated. Photographing the vocal folds can be valuable for this purpose.

The initial evaluation by the speech pathologist will include a history of the voice disorder, an analysis of current vocal use and abuse, as well as a description of the voice quality and respiratory pattern. In addition, most clinicians will obtain objective measures of vocal function, such as maximum phonation time, pitch range, habitual pitch and estimated optimal pitch. From these, specific goals for subsequent therapeutic intervention will be formulated.

For patients whose abusive habits have generated a space-occupying lesion on the vocal fold, therapy may commence either prior to or following surgery. Presurgical intervention may promote healing of tissues inflamed by continuing abuse. In addition, the patient is less likely to return to abusive modes of phonation after he/she is taken off vocal rest following surgery. Continuation of therapy after healing is complete will assist the patient in transferring the new vocal skills to all speaking situations. For the patient who has experienced deteriorating vocal quality with little or no ap-

preciable development of a space-occupying lesion, prompt vocal rehabilitation may circumvent the need for surgery.

The speech pathologist uses a variety of techniques to establish improved vocal tone. These methods are used either singly or in combination, depending on the needs and abilities of the patient. Below are some common techniques, along with comments regarding their implementation.

1. Initially, the clinician analyzes the patient's typical voice use to obtain a complete list, in order of importance, of each source of abuse. This process may extend over several weeks as the patient's awareness of his/her voice grows. Those factors which are found to be contributing significantly to the current state of the voice are eliminated or replaced by more desirable behaviors. For example, the patient may be unaware of habitual coughing or throat-clearing. Once it has been brought to the patient's attention, it can be reduced and, finally, eliminated.
2. Altering voice pitch is especially desirable for those who have artificially lowered the pitch of the voice. (As a note of interest, these people frequently complain of pain in the laryngeal area and often are found to have changes in the mucosa of the posterior third of the vocal fold, such as contact ulcer.) Pitch is elevated with the patient matching tones from a piano or pitch pipe until both patient and clinician are satisfied that laryngeal tone is clearer and speaking effort is reduced. Frequently, a lessening of laryngeal pain is noted after the patient begins using the new pitch habitually.
3. Deep muscle relaxation is of great benefit to patients who show abnormally high muscle tension in the laryngeal area. The patient is taught to contract, then relax specific muscle groups, noting the feelings imparted to those muscles. Over time, the patient learns to recognize and eliminate abnormal muscle tension outside the therapy setting. Voluntary relaxation of the laryngeal muscles greatly reduces tension in this area and promotes improved laryngeal tone. Contracting and relaxing of muscles may be accompanied by stretching and massaging extrinsic laryngeal muscles. The patient is taught to tilt the head toward the chest, then toward each shoulder, feeling the resulting pull on the muscles of the neck. Massage of these muscles may be added to promote greater relaxation.
4. In a state of relaxation, the patient is shown how to emit an audible sigh, beginning at a high pitch and dropping smoothly to a normal speaking pitch. Frequently, vocal quality is better in the higher portion of the pitch range and can be utilized as a model to be imitated at a more appropriate pitch.

These constitute just a few of the techniques used by speech pathologists to reduce laryngeal hyperfunction and improve vocal quality. The reader will note that voice rest was not included. Voice rest generally is not

regarded as a therapy technique per se, since the patient usually resumes his abusive vocal practices as soon as voice rest is terminated.¹ The laryngologist frequently uses voice rest in the case of severe laryngitis, or following laryngeal surgery, however, to promote tissue healing.

Summary

Effective treatment of the dysphonic patient who is a vocal abuser frequently requires the joint efforts of medical and speech practitioners. Both must understand the etiologic significance of vocal abuse in producing a variety of pathologic changes in the vocal folds, as well as the resulting perceptual changes in vocal quality. Referral of the patient for vocal rehabilitation may be made before or after surgical removal of the space-occupying lesion to aid the patient in achieving a more normal mode of phonation.

References

1. Boone, Daniel R.: *The Voice and Voice Therapy*, Prentice-Hall, Inc., Englewood Cliffs, NJ, 1977.
2. Sansone, F. and Emanuel F.: Spectral Noise Levels and Roughness Severity Ratings for Normal and Simulated Rough Vowels Produced by Adult Males, *J. of Speech and Hearing Research*, 13, 489-502, 1970. □

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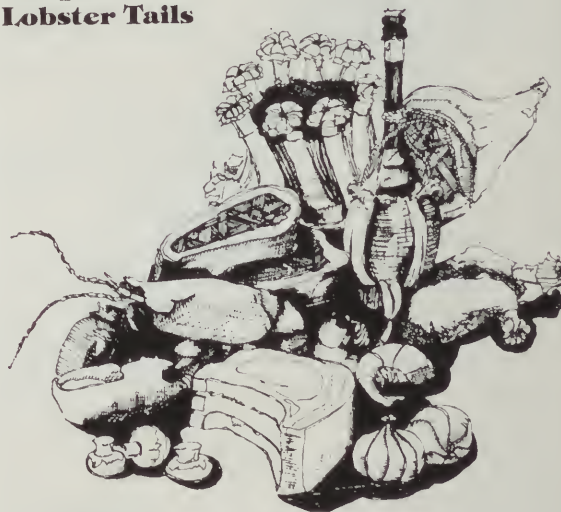
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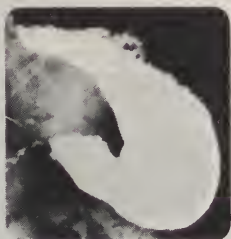
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

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For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

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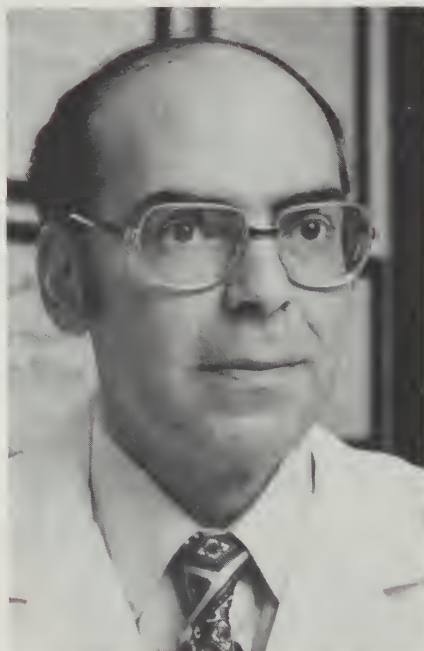
Doctors in the News

Officers Elected

The following are elected officers of the Maryland Society of Otolaryngology for 1979-80: President: **Dr. Haskins Kashima**; Secretary Treasurer: **N. Edward Nachlas, MD**; Executive Committee: **Dr. George Alderman** and **Dr. Cyrus Blanchard**, all of Baltimore.

American Heart Association Presents Award to Dr. Chris Papadopoulos

Dr. Chris Papadopoulos, Chief of Staff and Chief of Cardiology at South Baltimore General Hospital, was recently the recipient of the Gold Distinguished Service Award of the American Heart Association—Central Maryland Chapter. This is awarded for long and distinguished leadership and unusually excellent contributions to the Chapter. Dr. Papadopoulos, an Assistant Professor at the University of Maryland School of Medicine, has been Past President of the Central Maryland and the State Heart Associations. This is the first time ever that this award has been presented.



DR. PAPADOPOULOS

Solomon Snyder Receives International Psychiatric Prize

Solomon H. Snyder, MD, Distinguished Service Professor of Pharmacology and Psychiatry at the Johns Hopkins School of Medicine, received the Anna Monika Foundation Prize at a meeting of the World Psychiatric Association in St. Moritz August 30th. The \$10,000 First Prize is awarded for outstanding biological psychiatric research.

Dr. Snyder and his colleagues are well-known for their discoveries of opiate receptors in the brain and of enkaphalins, the normally-occurring, morphine-like substances which act upon the opiate receptors. Dr. Snyder shared the 1978 Lasker Award for basic medical research for this work, which was hailed as fundamental to solving the major human problems of the relief of pain and narcotic addiction.

The techniques Dr. Snyder developed to identify the opiate receptors have enabled him and others to monitor receptors for most of the neurotransmitters, or chemical messengers, in the brain. His discovery of the receptors for the neurotransmitter dopamine was followed by his demonstration that antischizophrenic drugs exert their therapeutic effects by blocking dopamine receptors. This, in turn, has led to his development of a blood test which permits monitoring of the effectiveness of such drugs.

The awards committee of the Anna Monika Foundation includes the major professors of psychiatry of European universities; chairman of the committee is Professor P. Kielholz, head of psychiatry at the University of Basle, Switzerland.

Dr. Johnson Appointed

John L. Green, Vice President for Operations/Administrator of Lutheran Hospital of Maryland, Inc., has announced the appointment of **Dr. Sandra Owens Johnson** as Medical Director of the Rosemont Community Doctors' Center.

Dr. Johnson received her MD from the University of Florida

School of Medicine, located in Gainesville. She interned and took her residency at the University of Maryland Hospital and the Baltimore Veterans Administration Hospital. Her background includes specific concentration in outpatient care, both emergency and non-emergency. She served as Assistant Director of emergency room services at University Hospital also.

Commenting on her new position, Dr. Johnson says: "My goal is to provide primary health care at the community level and to educate patients in the area of preventive medicine. If people do not understand their health problems, then the practice of poor health habits and the subsequent patterns of illness usually repeat themselves."

According to Dr. Johnson, "Emphasis on preventive medicine is an inherent part of the care provided at the Rosemont Community Doctors' Center. Patients are encouraged to schedule appointments with the same Center physician, resulting in continuity of care and the establishment of traditional patient-physician relationships."


One of the first primary care practices to be established on a hospital campus, the Rosemont Community Doctors' Center is lo-

cated at 800 Braddish Ave. in Baltimore, and is open from 8:30 AM-5 PM on Tuesdays, Thursdays and Fridays and from 8:30 AM-8 PM on Mondays and Wednesdays.

Opened a little more than a year ago, the Doctors' Center was funded through a \$500,000 grant award from the Robert Wood Johnson Foundation. □




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Drug Alert!

The following advance advisory notice to all practicing physicians from the Surgeon General of the Public Health Service, Dr. Julius Richmond, regarding the possible dangers of prescribing certain drugs to individuals who abuse alcohol, has been received. You may have already received this notice in your mail, but in case you have not, we bring it to your attention because we believe the message is urgent.

SIDNEY B. SEIDMAN, MD
Chairman, Committee on Drugs

Recent events have highlighted the importance of physicians and health professionals giving greater attention to possible dangers of prescribing certain drugs to individuals who abuse alcohol. During the past several years, there has been a major increase in this country in the medical and non-medical use of drugs. Concurrently, the wide use of alcohol by both men and women enhances the probability that alcohol and another drug will act simultaneously in many individuals, with serious and potentially-fatal consequences. Indeed, alcohol use in combination with other drugs accounts for approximately 20% of the total number of accidental and suicidal deaths per year which are drug-related.

Concern over these trends prompts me to alert the medical profession to the special problems of prescribing certain drugs for patients who consume alcohol.

I wish to remind all physicians and health professionals that:

Many commonly-prescribed drugs have altered therapeutic and/or adverse medical effects when taken with alcohol. These drugs

include not only sedatives, hypnotics, narcotics, antidepressants and tranquilizers, but also certain antihistamines, analgesics, anti-coagulants and anti-infective agents.

Minor tranquilizers as well as other CNS depressants are frequently used by patients in combination with alcohol despite warnings to the contrary. This combined use may produce adverse medical consequences. Moreover, the resultant potentiation of CNS depression can impair performance of tasks requiring alertness—such as driving—increasing the likelihood of injury and even death. The combination itself can lead to death by accidental overdose or by suicide.

The use of marijuana and other illicit psychoactive substances is widespread, and this use often occurs in combination with alcohol, or other licit psychoactive drugs.

Therefore, I urge all physicians and health professionals to:

1) Routinely document the history and scrutinize the pattern of alcohol consumption for individual patients to determine the possible relationship between presenting complaints and mixing drugs with alcohol;

2) Be alert to the possible interaction of prescribed, over-the-counter, or illicit drugs—singly or in combination—with alcohol;

3) Pay careful attention to the section in the package insert that deals with drug-alcohol interactions and consult the current medical literature and references for specific problems;

4) Limit as much as is practical the quantity of drugs dispensed with any one prescription and monitor the patient with regular follow-ups for unexpected reactions to the medication and

5) Consider, both in the choice of therapy and in the evaluation of the patient, the likelihood of the patient's adherence to your admonition (and that of warning label on the prescription) against using alcohol while taking medication.

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Attempted Rh Immune Prophylaxis After Massive Transfusion: A Case Report

By N. Mallya, MD; P.R. Sohmer, MD; R.B. Dawson, MD, FCAP and R.A. Cowley, MD

This article is from the Blood Transfusion Laboratories of the Department of Pathology and Maryland Institute of Emergency Medicine of the University of Maryland School of Medicine and Hospital at Baltimore, MD. Dr. Mallya is a staff Pathologist at Provident Hospital in Baltimore. Formerly, he was Assistant Medical Director of the Blood Bank and Transfusion Service of the University of Maryland Hospital. Dr. Sohmer is Acting Medical Director of the Blood Bank and Transfusion Service of the University of Maryland Hospital and Research Associate of the Blood Research Laboratory of the Department of Pathology of the University of Maryland School of Medicine, Baltimore. Dr. Dawson is Professor of Pathology and Associate Professor of Medicine at the University of Maryland School of Medicine and Director of the Blood Transfusion Laboratories of the University of Maryland Hospital, as well as Director of the Blood Research Laboratory of the Department of Pathology and Director of the Baltimore Rh Typing Laboratory. Dr. Cowley is Director of the Maryland Institute of Emergency Medicine and Professor of Surgery at the University of Maryland School of Medicine. For reprint and other data, contact Dr. Sohmer at the Blood Transfusion Laboratories of the University of Maryland Hospital, 22 S. Greene St., Balto., MD 21201.

Introduction

The literature contains relatively little information regarding patients treated with Rh-immune globulin for Rh-immune prophylaxis subsequent to transfusion of large volumes of Rh positive blood. In the present case report, after infusion of Rh positive erythrocytes in a life-threatening emergency, a large volume of Rh immune globulin was administered.

Case Report

A 17-year-old, white female was brought to the Maryland Institute of Emergency Medicine by helicopter from the scene of a motor vehicle accident on March 11, 1978. The patient suffered multiple facial abrasions, a comminuted fracture of the right femur and pelvic fractures. Insertion of a foley catheter revealed gross hematuria. A small, lower abdominal midline incision revealed gross hemorrhage within the peritoneal cavity. A precipitous fall in hematocrit necessitated infusion of three units of uncrossmatched group O, Rh positive concentrated red cells. Simultaneous serological testing revealed a recipient blood group and type of group O, Rh₀ negative, D^u negative. Splenectomy and exploratory laparotomy were performed. The patient was successfully resuscitated; and subsequently appropriate orthopedic and plastic surgery procedures were carried out without further complication.

Sixty-six hours after the infusion of Rh positive blood, 7,500 ug. of human anti-Rh immune globulin were begun and administered in divided doses over a 36-hour period without complication.

The patient has been followed with direct and indirect antiglobulin testing since administration of Rh immune globulin. At 24 and 72 hours post-therapy, the indirect antiglobulin test was positive to titers of 1:512. At six months following therapy, titers remained positive at 1:8.

Discussion

Although Rh immune prophylaxis with Rh immune globulin has proven effective after abortion, live birth and ectopic pregnancy, only isolated success has been reported after Rh incompatible blood transfusion.^{1,2} Three questions are paramount to appropriate therapy: 1) Time at which therapy must commence? 2) Dosage? and; 3) Percent incidence of non-response?

By convention, Rh immune globulin is administered within 72 hours after exposure; however, the basis for this schedule raises the question of whether administration at 96 or 120 hours would prevent sensitization. In the transfusion setting, therapy probably should be started with minimal delay.

Previous therapy failures may have occurred due to inadequate dosage of Rh immune globulin. Therefore, according to Pollack et al,³ a dosage of 20 ug./cc. packed cells is required. In those patients in whom successful immune prophylaxis after transfusion has been achieved, such a dosage was used.^{1,2} However, Pollack has suggested that a total dosage of 2,000 ug. may be effective against any volume of transfusion.⁴ Bowman et al² have suggested that with transfusion of 1,000 ml. or more Rh positive cells, partial exchange transfusion may be performed to reduce the number of circulating Rh positive cells.

From studies performed on human volunteers, Pollack et al^{4,5} have demonstrated a response rate of 68-82% in Rh negative individuals receiving 500 cc. of Rh positive blood. The patient may be a non-responder. This must be taken into consideration. In addition, some have suggested that transitory immune paralysis may occur following massive transfusion, thus preventing antibody synthesis.

In the present patient, antibody titers are positive at six months post therapy. Since the half-life of Rh immune globulin is 30 days, this may indicate presumptive sensitization and failure of Rh-immune prophylaxis.

References

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□

How NOT to be Sued for Malpractice

By JEAN-MAURICE POITRAS, MD

For reprint and other data, write Dr. Poitras at 107 Edgerton Rd., Towson, MD 21204.

William Smellie (1697-1763), the great English obstetrician of the 18th Century, was immortalized because of his great work **The Theory and Practice of Midwifery**, originally published in three volumes, which came out at different periods. The first volume containing the **Principles and Practice of Midwifery**, was dated 1752, but was actually released in the latter part of 1751. Volumes Two and Three were published respectively in 1754 and 1764, the latter one year after his death. These latter two volumes are taken up with 530 case histories and their clinical observations. There were repeated editions and translations into many languages.

The following case is taken from Volume III of Smellie's great work. The case is reproduced in its entirety and, on reading, no further explanation is needed for the above title to this historical note.

Cases in Midwifery—Page 506, Number 3—Case 1

Several years ago, I delivered a woman in May Fair, of a small child. In turning and delivering it, by the feet, I found the bones of one of the arms snap asunder; a circumstance which surprised me the more, as I never turned and delivered a child with greater ease, or in a slower or more cautious manner. Indeed, I am persuaded it happened principally from the smallness of the bone. I said nothing, but wrapped the child up in its blanket, and laid it on the lap of one of the assistants, desiring her not to move it, till I had got the woman put right in bed. I then examined the arm, and told the nurse that it was a little hurt in the delivery, but would soon recover. As the child was poor of muscular flesh, I only applied a compress dipped in brandy and water, and with a single roller kept the ends of the bones together, which I found was sufficient at the time, and to prevent suspicion of a fracture, I held the arm during the dressing. I desired the nurse not to let it lie on that side, and not to undress the body of the child till I was present. As I visited my patient every day, I had the opportunity of renewing the dressings as there was occasion, and the arm recovered without the parents having any other suspicion than of a strain in the delivery.

*Editor's Note: What worked for Dr. Smellie in 1750 in England may not work in 1979 in the United States. If there was negligence in the delivery of the infant, failure to so inform the parents might be considered a fraudulent concealment and would toll the statute of limitations from running. ("Toll" is a legal term meaning to **stop** or to **hold in obedience**.) Even in the absence of fraud, the statute might be tolled until the parents discovered the negligence. If there was not negligence in the delivery (the bone broke is a result of a nonnegligent complication of the procedure) then Dr. Smellie would have little grounds on which to fear a malpractice suit (at least in 1750 in England)!*

JIM ZIMMERLY, MD

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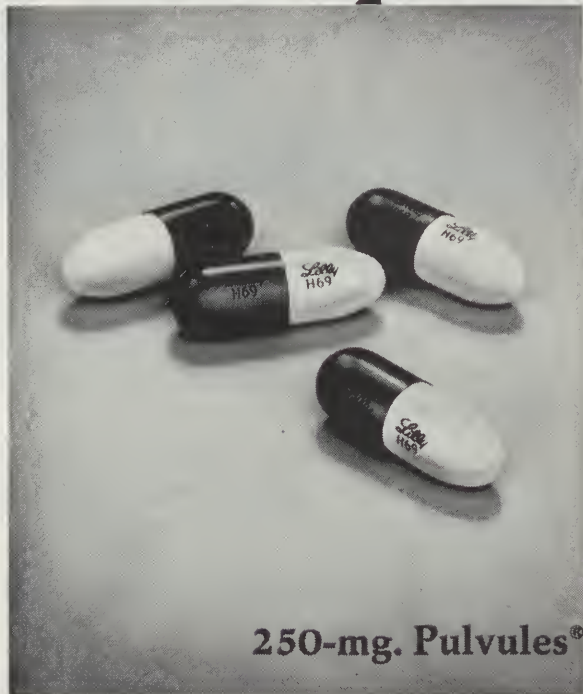


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A Conversation With Donald Sharp Fredrickson, MD, Director of the National Institutes of Health: An Exclusive JOURNAL Profile/Interview

By Blaine Taylor

Contact Mr. Taylor, **JOURNAL** Managing Editor, for reprint and other data c/o the **JOURNAL**, 1211 Cathedral St., Baltimore, MD 21201.

Introduction

On Feb. 14, 1977, there appeared the following **Editorial** in the AMA publication **American Medical News**: "DR FREDRICKSON: "We congratulate the Carter Administration and HEW Secretary Califano for selecting a good man to run the National Institutes of Health. Donald S. Fredrickson, MD has been conducting the affairs of the Institutes with scientific distinction since his appointment by the Ford Administration.

"We haven't the foggiest notion



whether Dr. Fredrickson is a Democrat or Republican, and don't care.

"In this case, the Administration made two good choices. They chose Dr. Fredrickson, and they chose to keep politics, as much as is possible, from Federal science policy."

Elsewhere in the same issue appeared this short story, entitled **NIH Director to Keep Post**: "Officials at the National Institutes of Health breathed a sigh of relief at the announcement that NIH Director Donald S. Fredrickson, MD will be retained under the Carter Administration.

"The decision by Health, Education and Welfare Secretary Joseph Califano capped a nervous several weeks at the prestigious Institutes, where many expressed concern that the scientific spirit of NIH would be damaged if the popular Dr. Fredrickson had been ousted.

"Califano visited the NIH 'campus' in nearby Bethesda, MD



THE 300-PLUS ACRE NIH CAMPUS AT BETHESDA, MD.

(Picture courtesy of NIH.)

Chronology of Important Events in the Development of NIH Programs

- 1887 Research laboratory founded at Marine Hospital, Staten Island, NY, to meet new responsibilities of Marine Hospital Service.
- 1891 Hygienic Laboratory moves from Staten Island to Service headquarters, Washington, DC
- 1902 Advisory Board for the Hygienic Laboratory established; later to become National Advisory Health Council. Act of Congress makes Service responsible for biologics control.
- 1912 Name of Public Health and Marine Hospital Service changed to Public Health Service (PHS).
- 1930 Hygienic Laboratory becomes National Institute of Health (NIH) under the Ransdell Act.
- 1937 Congress authorizes National Cancer Institute (NCI). First research grants.
- 1938 National Institute of Health moves to land donated by Mr. and Mrs. Luke I. Wilson at Bethesda, MD. First research fellowships (NCI).
- 1944 Public Health Service Act, giving general research authority.
- 1945 Research grants extended, with central NIH responsibility.
- 1946 Division of Research Grants (DRG) established to review and evaluate applications for NIH grants to non-Federal institutions and scientists.
- 1947 First training grants (NCI). DRG starts research fellowship program.
- 1948 National Heart Institute authorized; other laboratories regrouped to form National Microbiological Institute (NMI), Experimental Biology and Medicine Institute (EBMI) and National Institute of Dental Research (NIDR). NIH becomes National *Institutes* of Health (NIH).
- 1949 Mental hygiene program of Public Health Service transferred to NIH and expanded to become National Institute of Mental Health (NIMH).
- 1950 "Omnibus Medical Research Act." National Institute of Neurological Diseases and Blindness (NINDB) and National Institute of Arthritis and Metabolic Diseases (NIAMD) established, the latter absorbing EBMI.
- 1953 Public Health Service becomes a constituent of newly-created Department of Health, Education and Welfare (DHEW). Clinical Center opens.
- 1955 NMI becomes National Institute of Allergy and Infectious Diseases (NIAID). Division of Biologics Standards formed, assuming NMI's biologics control function. Division of Research Services (DRS) created.
- 1956 Health Research Facilities Act, authorizing program of matching grants for research construction in non-Federal institutions.
- 1958 Division of General Medical Sciences (DGMS) created.
- 1960 PHS Act amended to provide for general support of research and research training programs in nonprofit institutions. International Health Research Act extends NIH international programs.
- 1962 Division of Research Facilities and Resources (DRFR) formed. National Library of Medicine (NLM), constituent of PHS since 1956, moves to NIH reservation.
- 1963 Two Institutes (authorized in 1962) established — National Institute of General Medical Sciences (NIGMS), superseding DGMS and National Institute of Child Health and Human Development (NICHD).
- 1964 Division of Computer Research and Technology (DCRT) established.
- 1965 Division of Regional Medical Programs (DRMP) created to administer the "Heart Disease, Cancer and Stroke Amendments of 1965."
- 1966 Division of Environmental Health Sciences (DEHS) established.
- 1967 National Institute of Mental Health becomes separate bureau of PHS.
- 1968 John E. Fogarty Interantional Center for Advanced Study in the Health Sciences (FIC) established. National Eye Institute (NEI) created. NINDB becomes National Institute of Neurological Diseases and Stroke (NINDS).
PHS reorganized under Assistant Secretary for Health and Scientific Affairs, DHEW. Bureau of Health Manpower (BHM), formed in PHS the previous year, and NLM become constituents of NIH, DRMP transferred to new Health Services and Mental Health Administration, PHS. Lister Hill National Center for Biomedical Communications established at NLM.
- 1969 DEHS becomes National Institute of Environmental Health Sciences (NIEHS). National Heart Institute renamed National Heart and Lung Institute (NHLI).
- 1970 Family Planning Services and Population Research Act.
- 1971 National Cancer Program established. Sickle Cell Disease Program initiated in NHLI.
- 1972 NIAMD becomes National Institute of Arthritis, Metablism and Digestive Diseases (NIAMDD). National Heart, Blood Vessel, Lung, and Blood Disease Program established. Division of Biologics standards transferred to Food and Drug Administration (FDA-PHS), where it becomes Bureau of Biologics. NCI and NHLI gain bureau status within NIH. National Cooley's Anemia Control Act.
- 1973 PHS reorganization establishes new agencies: Health Resources Administration (HRA), Health Services Administration (HSA), Center for Disease Control (CDC), and Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Bureau of Health Manpower Education (BHME, formerly BHM) transferred to HRA.
- 1974 Sudden Infant Death Syndrome Act. National Institute on Aging (NIA) established. National Research Act revises research training authority and established national commission for protection of human subjects of research. National Diabetes Mellitus Research and Education Act. President's Biomedical Research Panel established.
- 1975 National Arthritis Act. NINDS becomes National Institute of Neurological and Communicative Disorders and Stroke (NINCDS). National commissions for epilepsy and Huntington's disease.
- 1976 NHLI becomes National Heart, Lung, and Blood Institute (NHLBI). Advisory boards created for diabetes and arthritis. National commission on digestive diseases established.
- 1977 Task force on environmental cancer and heart and lung disease appointed.
- 1978 NIH and new National Institute for Handicapped Research to coordinate studies. President's commission for study of ethical problems and a national center for health care technology created.

to make the announcement.
"To applause from more than 500 NIH workers, Califano said research is too important for partisan politics.

"The NIH Director is a Presidential appointee. Dr. Fredrickson...was appointed by President Ford in 1975.

"Depoliticization does not mean scientists can be isolated from human concerns," Califano warned. He said scientists must still expect pressure to improve medical care and conquer diseases and do so at lower costs."

NIH Components

As things turned out, Dr. Fredrickson survived Secretary Califano in the Carter Administration, and still holds sway over the mammoth organization from his office in Room 124 of Building Number One (where he was interviewed for the Journal on July 24, 1979). From over his Oriental rug-carpeted desk, the 55-year-old former cardiology researcher directs the affairs of the 11 "National Institutes:" Eye; Heart, Lung and Blood; Allergy and Infectious Diseases; Arthritis, Metabolism and

Digestive Diseases; Environmental Health Sciences; General Medical Sciences; Neurological and Communicative Disorders and Stroke, Aging; Dental Research; Child Health and Human Development and Cancer, plus the NIH hospital, the Clinical Center, of which he told the Journal, "It has over 500 beds and more than 800 laboratories, making it unique in the world as the biggest academic research hospital facility."

There are also the world-famous National Library of Medicine (which, through the MEDLARS terminal computer hook-up, is linked directly to Med-Chi) and several "Divisions" of NIH, too: Computer Research and Technology; Research Grants; Research Resources and Research Services.

Concerning its more than 12,000 employees (of whom about 2,200 hold doctoral degrees) located on its main 306-acre campus at Bethesda, MD (plus seven other campuses, such as that at Research Triangle Park, NC), the official 1978 NIH Almanac states: "From modest beginnings in a one-room Laboratory of Hygiene in 1887·

(renamed the Hygienic Laboratory four years later), the National Institutes of Health has evolved into one of the world's foremost and prestigious biomedical research centers. An agency of the Department of Health, Education and Welfare, the NIH is today the focal point for Federal biomedical research and support of research.

"Its mission is to improve the health of all Americans. To achieve this goal, the NIH conducts biomedical research in its own laboratories; provides grants to non-profit organizations and institutions for research and for medical education, including improvement or construction of library facilities, buildings, equipment and other resources; provides grants for the training of research investigators and supports biomedical communications through programs and activities of the National Library of Medicine... NIH maintains hundreds of laboratories containing complex and highly sophisticated research equipment..."

A summary table in the NIH Almanac shows that in 1947, the



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 - 6 National Institute of Child Health & Human Development; National Eye Institute; National Institute of Arthritis, Metabolism & Digestive Diseases
 - 7 National Institute of Allergy & Infectious Diseases
 - 8 National Cancer Institute; National Institute of Allergy & Infectious Diseases; National Institute of Neurological and Communicative Disorders and Stroke
 - 9 National Institute of Mental Health; National Institute of Neurological and Communicative Disorders & Stroke; National Eye Institute
 - 10 Clinical Center
 - 10A Surgical Wing
 - 11 Boiler and Refrigeration Plant
 - 11A Incinerator Building
 - 12 Division of Computer Research and Technology; Fire House; Garage
 - 12A Division of Research Services; Division of Computer Research and Technology; Office of Program Planning and Evaluation. Division of Engineering Services
 - 13 Office of Materiel Management; Plant Engineering Branch; Laundry; Engineering Design Branch; Construction Engineering Branch; Environmental Services. Biomedical Engineering & Instrumentation Br., DRS.
 - 14A, B, C, D, E, F, G Animal and Animal Feed Building, Veterinary Resources Br.
 - 15K Wilson House, National Institute of Mental Health
 - 16 Fogarty International Center
 - 16A Fogarty International Center
 - 17 Electrical Power Vault
 - 18 Perinatal Biology Lab., NICHD
 - 20 Apartment
 - 21 Radiation Safety, DRS; Radiopharmaceutical Section, Nuclear Med. Dept., CC
 - 22 Grounds Maintenance Building; Transportation
 - 25 Chemical Storage
 - 26 Chemical Disposal
 - 27 Chemical Storage
 - 28 Experimental Surgery & Clinical Medicine Sec., VRB, DRS.
 - 28A Veterinary Resources Branch Comparative Pathology Section
 - 29 Bureau of Biologics (FDA)
 - 29A Bureau of Biologics (FDA)
 - 30 National Institute of Dental Research
 - 31 General Office Building
 - 32 Greenhouse; National Institute of Mental Health
 - 34 Chilled Water Plant
 - 35 Cafeteria
 - 36 Natl. Inst. of Mental Health; Natl. Inst. of Neurological and Communicative Disorders and Stroke; Natl. Inst. of Child Health & Human Development; Natl. Heart, Lung, & Blood Inst.
 - 37 National Cancer Institute
 - 38 National Library of Medicine
 - 41 National Cancer Institute; Emergency Virus Isolation Facility
 - 46 Electrical Power Vault
- MLP6 Multi Level Parking 6.



total national investment in biomedical research and development was about \$87 million; in 1978, it was roughly \$6.1 billion. Of

this amount, the annual Federal investment has grown from about \$27 million to about \$3.8 billion, which represents almost two-thirds

of the biomedical research and development expenditures for the nation. Today, the NIH accounts for close to 40% of support from all

sources, most of it to non-profit institutions, particularly universities. Nearly 90% of the total NIH budget of some \$3.2 billion goes to support research conducted by investigators at universities, medical centers, hospitals and other, (mostly non-profit) research institutions. More than 2,500 institutions in every state and in several foreign countries are the recipients of NIH funds."

The Director

The man at the center of this giant behemoth, Dr. Fredrickson, lives in suburban Bethesda with his wife—the Dutch-born Henrietta Priscilla Dorothea Eekhof Fredrickson—and their two sons; Eric, 23, a student of history at Georgetown University and Rurik, 16, whose name derives from one of the three Viking founders of the Soviet city of Novgorod in Russia. Rurik attended Walt Whitman High School.

Dr. Fredrickson's official biography (as published in the 1978 NIH Almanac) states:

"Dr. Donald S. Fredrickson, internationally-known authority and researcher in lipid metabolism and its disorders, became Director of the National Institutes of Health on July 1, 1975. Immediately prior to this appointment, Dr. Fredrickson had served for one year as President of the Institute of Medicine of the National Academy of Sciences.

"His association with NIH, however, spans more than two decades, beginning in 1953, when he joined the scientific staff of the then-National Heart Institute (renamed the National Heart, Lung and Blood Institute in 1976) as a Clinical Associate.

"During his long research career in the Federal service, Dr. Fredrickson has held numerous positions at NIH, several in the Heart Institute simultaneously. From 1955-61, he was a member of the Senior Research Staff of the Laboratory of Cellular Physiology and Metabolism. Dr. Fredrickson then served as Clinical Director (1961-66), while continuing his re-

search as Head of the Section on Molecular Diseases, Laboratory of Metabolism (1962-66). He was appointed Institute Director in 1966, serving in that capacity until 1968. Dr. Fredrickson combined this executive responsibility with research as Chief of the Molecular Diseases Branch (1966-74) and as Director of Intramural Research (1967-74.)

"His earliest research interests centered on the mechanisms of synthesis, transport and the metabolism of fats. These studies also investigated the effectiveness and mode of action of different drugs and diets in reducing cholesterol and other fats in the blood. Dr. Fredrickson later conducted and directed research directed at the structure of the plasma lipoproteins, their importance in the transport of fats and the genetic factors regulating their metabolism and concentration in blood. It was during this period that Dr. Fredrickson discovered two new genetic disorders: Tangier disease (absence of high density lipoproteins)

DHEW: National Institutes of Health
1980 US SENATE ALLOWANCE
Summary by Appropriation
(Budget Authority in thousands)

	1979 ¹ Comparable	1980 President's Budget	1980 House Allowance	1980 Senate Allowance	Change
IRDs:					
Cancer	\$ 936,677	\$ 936,958	\$ 961,158	\$1,000,000	\$38,842
Heart	506,384	507,344	527,544	527,544	—
Dental	65,213	66,118	68,318	67,000	- 1,318
Arthritis	302,767	305,746	341,246	315,000	-26,246
Neurology	212,365	212,322	240,622	242,000	1,378
Allergy	191,328	190,202	215,402	200,000	-15,402
General Medical Sciences	277,628	280,378	312,478	304,000	-8,478
Child Health	200,843	204,381	208,981	204,000	-4,981
Eye	105,192	104,528	107,528	113,000	5,472
Environmental Health	78,260	79,012	83,912	83,912	—
Aging	56,911	56,510	68,910	70,000	1,090
Research Resources	154,164	154,199	169,199	164,000	-5,199
Fogarty Center	8,989	8,989	8,989	8,989	—
Subtotal, IRDs	3,096,721	3,106,687	3,314,287	3,299,445	-14,842
National Library of Medicine	41,431	41,431	42,431	44,000	1,569
Office of the Director	20,427	21,062	21,062	21,062	—
Buildings and Facilities	30,950	3,250	3,250	3,250	—
TOTAL, NIH	3,189,529	3,172,430	3,381,030	3,367,757	-13,273

¹ Includes supplemental request for population; rescission of Child Health Facility and transfer for OD pay costs.

Note: Senate allowed an increase of 70 positions over the President's Budget for aging. □

and cholesterol ester storage disease, a lysosomal enzyme deficiency.

"In 1965, Dr. Fredrickson and coworkers introduced a system for identifying and classifying blood-lipid abnormalities on the basis of plasma lipoprotein patterns. From this work came the recognition of three new monogenic causes of hyperlipidermia; type 3 hyperlipoproteinemia, type 5 hyperlipoproteinemia and what is now called familial hypertriglyceridemia. The system received prompt acceptance by the World Health Organization, was extended to all textbooks and reports on this subject and is now used widely by laboratories here and abroad.

"Research findings of Dr. Fredrickson and colleagues have also contributed significantly to new knowledge on apolipoproteins, including descriptions of several previously unknown apoproteins and the completion of the amino acid sequence of various apoproteins and other data concerning their function and structure.

"Dr. Fredrickson was born Aug. 8, 1924 in Canon City, CO. He re-

ceived both his BS (1946) and MD degrees (1949) from the University of Michigan, and was certified by the American Board of Internal Medicine in 1957. He did post-graduate work at Peter Bent Brigham and Massachusetts General Hospitals and the Harvard Medical School prior to coming to NIH.

"He is a member of numerous professional societies, among them: Alpha Omega Alpha, American Academy of Arts and Sciences, American Association for the Advancement of Science, American College of Cardiology (Fellow), American College of Physicians (Fellow); American Federation for Clinical Research; Phi Beta Kappa; Phi Kappa Phi; American Physiology Society; American Society for Clinical Investigation; American Society of Human Genetics; Association of American Physicians; British Cardiac Society (corresponding member); Harvey Society (honorary); Institute of Medicine (NAS); International Society of Cardiology; National Academy of Sciences; Medical Society of Sweden (honorary) Institute of Society,

Ethics and the Life Sciences (associate member); American Heart Association, Council for the Study of Arteriosclerosis; Honorary Fellow of the Council on Clinical Cardiology, Deutsche Gesellschaft für Innere Medizin (corresponding member) and the Peripatetic Club.

"He is also a member of the Advisory Council of the American Center for Chinese Medicine, a life associate member of the Intra-Science Research Foundation and has served on numerous editorial boards.

"Dr. Fredrickson's research achievements have won him many honors and awards. These include the Convocation Gold Metal Award of the American College of Cardiology (1967), the James F. Mitchell International Award for Heart and Vascular Research (1968). The DHEW Distinguished Service Award (1971), the **Modern Medicine** Distinguished Achievement Award (1971) and others.

Additional honors accorded Dr. Fredrickson include election to the National Academy of Sciences (1973), the Jiminez-Diaz Award (Madrid), the Intrascience Award

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(1974), the La Modannina Prize for Science (Milan, 1975), the American College of Physicians Award (1976) and, in 1977, an honorary Doctor of Medicine from Karolinska Institutet and an honorary Doctor of Science from the University of Michigan."

The Interview

Dr. Fredrickson, I know that you serve "at the pleasure of the President," but to whom do you actually report?

I report directly to the Surgeon General of the US, Public Health Service, who is also the Assistant Secretary for Health, and through him, to the Secretary of HEW.

Is NIH under both the Public Health Service and HEW?

Yes, it is, because the Public Health Service is really a principal operating component of HEW—it's the "h" in Health—but not all. "H" in Health is two things: PHS and health financing.

Is NIH Manageable?

Can one man—ANY ONE person, really—adequately supervise all of this? It's almost like being

President of the world! I guess this is a type of question like "Can anyone adequately be Governor of California or President of the US?"

Yes, you can! I think that it's for others to **judge**, but my own view is that you can. Most of NIH's Institutes were set up by individual statute. They get separate appropriations of money from Congress; in fact, in the legislation that authorizes NIH, the Director is barely mentioned! I am deeply involved, however, in their planning and budget preparation, and join with the Institute Directors in presenting and defending their budget requests to Congress.

The job of the Director is really to take this great collective and set a common style for it, and by persuasion—rather than by raw authority—convince people that they ought to do certain things. I have to choose the Institute Directors and do a lot of appointing, but it's possible, I think, to govern such an organization from a central focus because that government is, primarily, a modulating influence.

Did you know that your persuasion analogy was pretty much

the definition of the Presidency that Harry S. Truman used?

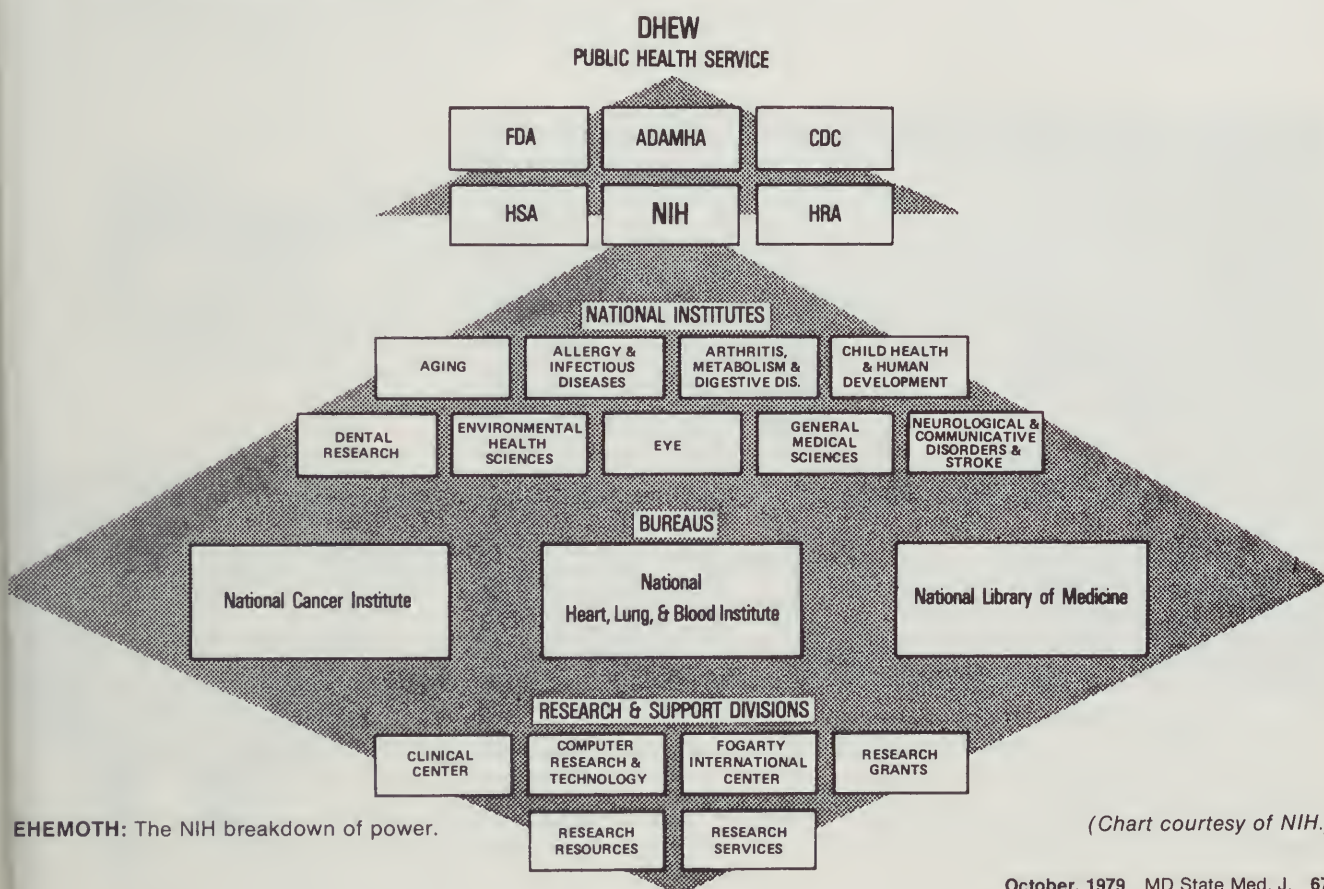
Really? Well, I understand that definition, and I also understand where the buck stops—because it, too, stops here—which is something **else** he said!

He said, also, as he was going out of office, of his successor, Dwight Eisenhower, "Poor Ike! He'll come in here and give orders like he used to in the Army and nothing will happen!"

Well, I think that's true. It's like the Presidency in a very limited way, where the Cabinet would represent the Institutes. There's a lot of independent life to agencies and to bureaucracy. You can only modulate its style, but you **can** make a lot of difference, though, by setting the tone and insisting upon it.

Do you see yourself as the person merely coordinating all this? Do you interfere with your subordinates or give them their heads and let them go?

They get lots of delegated authority—I don't care to do their jobs for them. I wouldn't have time to do that anyway, as I have to spend a lot of time with the Congress. I'm the interface between



EHEMOTH: The NIH breakdown of power.

(Chart courtesy of NIH.)

this campus and both the Congress and the Administration.

Congressional Relations

Before what Congressional committees do you appear?

I appeared 34 times before the 95th Congress—that included a lot of Committees—but the principal ones were the health subcommittees of the House and Senate Appropriations Committees, and the health subcommittees of the two authorizing committees—the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce.

Working With EMK

How do you find Sen. Kennedy to work with?

I enjoy working with Kennedy. I think that he's vibrant and very interested in matters of health, is informed and, of course, has a big and active staff so that he keeps us on our toes.

Do you see him as someone hostile to you? Doctors seem to think he's inimicable to their best interests at times.

When I first came to NIH, I think he had a particular view about scientific research and academic medicine that was somewhat sharper in a critical sense than it is today. I think we've come to

know each other. I don't find him difficult to work with, no. The people I represent are well-respected by the Congress as a whole.

Is academic medicine viewed in Washington as in any way partisan Democrat or Republican?

No, it doesn't have a party label, but one that all elite institutions do—self-serving—in the eyes of many people in politics. Its' not that, but it is a special constituency, like all the other interests in Washington.

NIH/CDC

Do you have anything to do with the Center for Disease Control in Atlanta?

That's one of our sister agencies, of which there are six, and with which we work very closely. It's not **under** me, though.

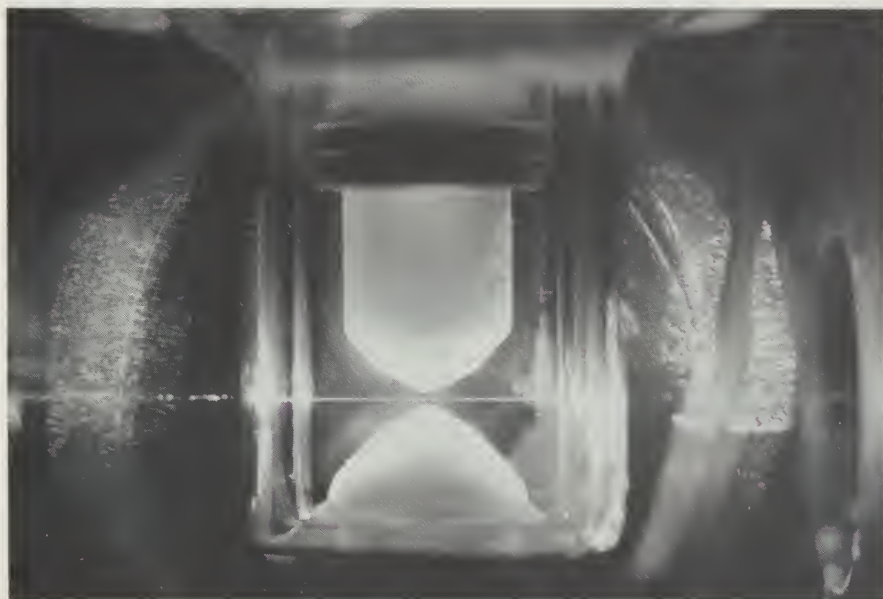
Should it be?

No, it **should** be separate, because it carries out both service programs and quasi-regulatory activities, and those are two things we don't think NIH should ever do.

Swine Flu '76

Let's discuss the swine flu epidemic of 1976, which was both predictable and predicted. Did NIH have anything to do with that?

Influenza is a problem that's
(Continued on page 71)



PAP TEST USING LASER TECHNOLOGY: One of the many uses for the laser in medical research is as a light source to detect premalignant and malignant cells from Pap test specimens. Shown here are gynecologic cells passing in a stream through the laser beam where each cell is analyzed. Abnormal appearing cells can be sorted from the rest of the cells and later examined by a pathologist for evidence of cancer. (Photo courtesy of NIH.)

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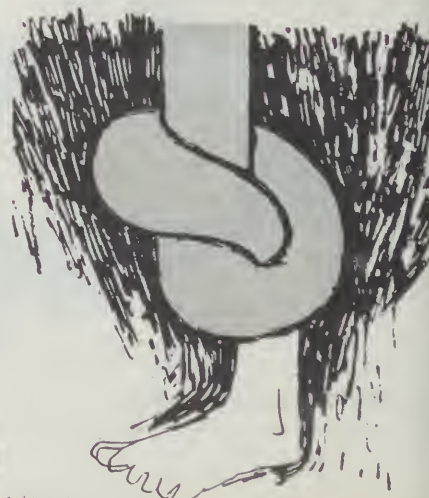
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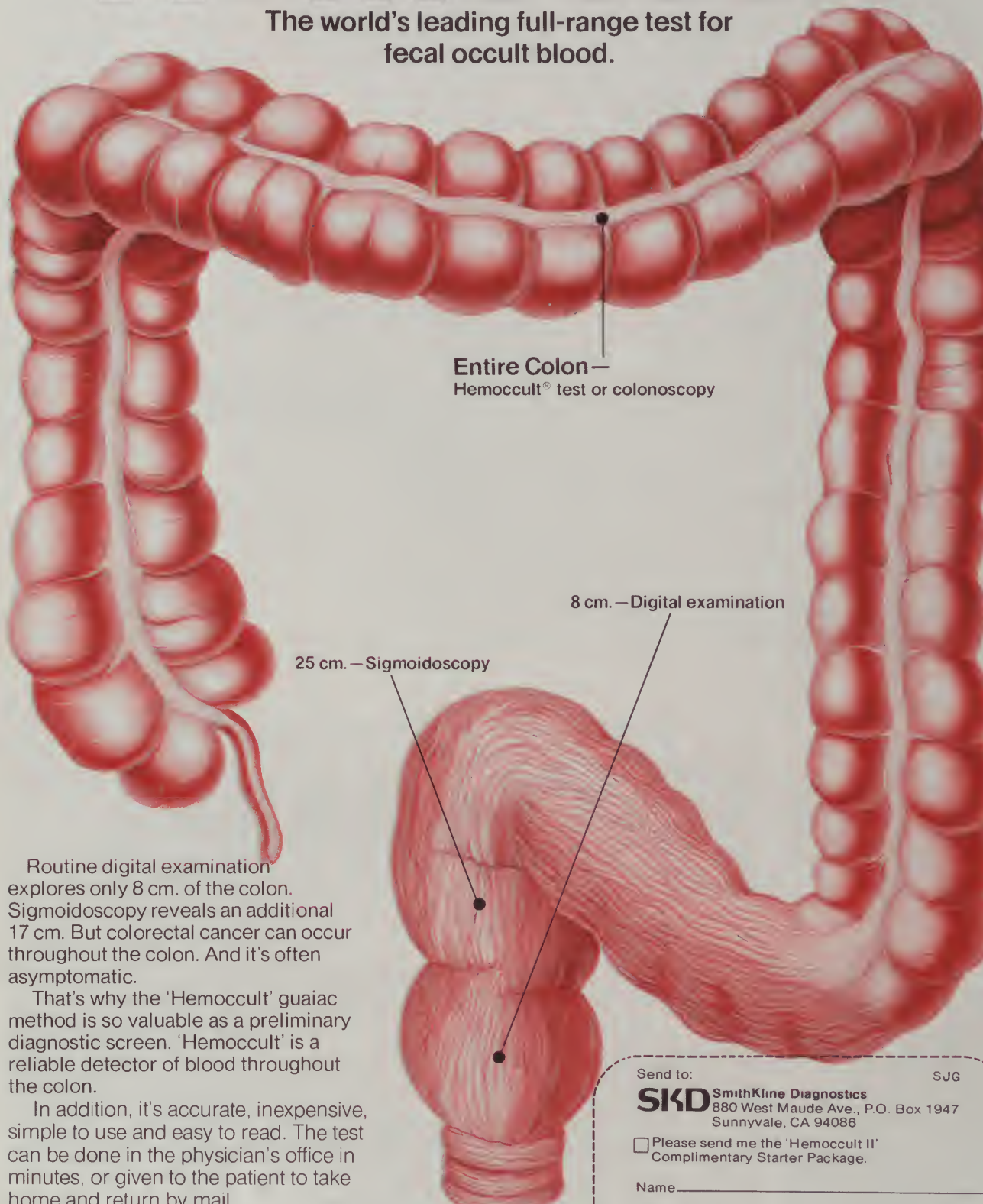
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monitored by a troika: the National Institute of Allergy and Infectious Diseases, the Center for Disease and the Bureau of Biologics of the Food and Drug Administration (FDA). These three organizations do research, develop new vaccines, do surveillance of epidemics, detect new strains and, finally, the testing and certification of those vaccines.

Are you the man who calls the President and says, "Mr. President, we have a swine flu epidemic on our hands?"

No, that should be the Surgeon General, nor do I tell him, because the epidemic thing is really in the purview of the CDC. They are the epidemic surveillance team. During the '76 outbreak, our Institutes helped with the research aspects of developing the vaccines, though.

Biological Warfare Role

What about in the case of biological warfare used against the US? What would be the role of NIH?

The CDC is the strike force that's called first; they, then, call upon us for assistance, technical exploration, developmental research and whatever else may be

required to improve our overall knowledge of the situation.

"Legionnaire's Disease"

Did you have anything to do with the so-called "Legionnaire's Disease?"

Again, we played a secondary role to CDC.

NIH's Central Thrust

What is, in your mind, the biggest activity that NIH has now?

The biggest—the single most important—is funding the investigator-initiated grants to the 16,000 investigators whom we support by that means in this country.

Combatting Cancer

How, if at all, does NIH link itself with state and local efforts to combat cancer, such as at the Baltimore Cancer Research Center and at Johns Hopkins?

The Cancer Institute—through its comprehensive cancer centers and other large grants—has a tremendous influence on the treatment of cancer in this country. It touches the lives of somewhere between a tenth and a third of all people who have cancer in the

sense of making available drugs under tests or participating at some point in their care.

I know you can't say for sure, but, in your opinion, will there be a cure for cancer in your lifetime or even in mine?

We will understand the causes of many kinds of cancer in our lifetimes without any question; whether that leads to cure or not I'm not sure, but I think it probably will.

Medical Détente

One of the offsprings of détente may well be medical coordination with the Union of Soviet Socialist Republics (USSR), the People's Republic of China and other Eastern Bloc countries wherein we trade health information back and forth. Is any of that going on now?

NIH has a score of arrangements with different countries—many of them broader than NIH through the Public Health Service. We have been the first among many national organizations to have medical and scientific diplomacy, certainly in the area of biology, so that we've been cooperating

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for decades with many countries. We have a research agreement with the Soviet Union that contains 10-12 major categories. They come here one year, we go there, etc. Agreements have also been signed with the People's Republic of China. We have the Fogarty International Center that keeps tabs on all those things. We are the major international activity of HEW and cover all the major disease areas: cancer, health, environment—virtually the whole spectrum.

Some Components Discussed

Discuss in broad, general terms, if you will, some of the various Institutes comprising NIH.

Well, the National Institute for Child Health and Human Development has two major centers, one for population research and another for maternal and child health. It's one of the non-categorical Institutes that's responsible to give us more wanted and healthier babies and to start them on a healthy life.

The National Eye Institute is one of the younger Institutes. It does a lot of research, and has been, I think, a major factor in organizing the eye research community, and has greatly increased the level of quality of eye research related to vision in the US.

The National Institute on Aging is the newest one, is still in its infancy and waiting to get more support. It will also be interesting as one of the first organizations for introducing social sciences along with the hard sciences into research in what certainly will be a major public health problem.

The National Institute for General Medical Sciences is the basic science Institute. It does **not** have an intramural research program—and is the **only** Institute that doesn't, but is very important for supporting basic research that's not related to disciplinary medicine.

The National Heart, Lung and Blood Institute is the second largest, and is responsible for an enormous area of pathology...

What're their projections for the next five years over where they'll be heading?

There's a big drop in mortality from coronary artery disease in this country. Part of that is due to vigorous control of hypertension and better ways to treat it. That's still a major activity of theirs. There's a lot of heart disease to be worked upon—arteriosclerosis. The Institute's busy activating a vigorous approach to diseases of and structure of the lung and has the major purse for research on disease of the blood, too.

The Environment

Environmental Health Sciences provides the knowledge **behind** regulation...

If you had to come down—in your Congressional testimony—on the side of keeping environmental regulations where they are or relaxing them in favor of industry, which would you do?

I'd be as tough as I could within reason to maintain the health standards of the environment. We're going to **have** to make certain concessions, but we do that very reluctantly. NIH **doesn't** regulate, however.

Peering Into the Future

How do you view the future at NIH?

We regard tomorrow's medicine as today's research and, therefore, we—collectively—have a tremendous influence on medical practice. We want to make sure that our efforts **are** meaningful, i.e., that they eventually result in practical things. We started last year a new exercise on technology consensus which will touch the lives of many practitioners where we catalyze the organization of people from outside of practice and the scientific community, to try to come to grips with what is the state of the art in health care practices. One thing we're now examining is: What **really is** the value of giving estrogen to post-menopausal women? As we get nearer to those tough questions, we're trying to provide answers and help the community to find its **own** answers, because standard-setting **is** coming. Just as we have National Health Insurance waiting in the wings, you can be sure that the setting of standards for practice for remuneration is only around the corner. We would like to help the medical community to really do it **by itself**. If it doesn't—if we **don't** all manage to do that—than it **will** be done by some people in dark offices, and we'll have a lot less to say about it!

NHI and NIH

Since you raise that spectre, how WILL the passage of NHI affect what NIH does?

It'll mean we'll have to accelerate some of these exercises and



TISSUE PROCESSOR: Technician in the NCI's Laboratory of Pathology loads the histomatic tissue processor with a basket of tissues to be processed. The basket holds small, disc-shaped containers of tissue specimens. The instrument automatically processes 100 of these specimens at one time, immersing them in a series of solvents for fixing, dehydrating and clearing and in paraffin for infiltration. Laboratory technicians prepare histologic slides from these processed tissues for close scrutiny under the microscope by a pathologist to determine whether any of the cells are cancerous. (Photo courtesy of NIH.)

perhaps be very attentive to—as we think we are **now**, but even more so—the big problems that cost all the money. We'll have NHI within five or 10 years whether Sen. Kennedy is its broker or not. **Somebody** will do it.

Thank you, Dr. Fredrickson.

Acknowledgments

The author thanks the late **Journal** Editor Dr. C. Thomas Flotte, for suggesting this story; Mrs. Mildred Chronister for secretarial service and Dr. Fredrickson's own able staff members: Mrs. Bel Ceja and Mrs. Gretchen Sharpe. □

Doctors in the News

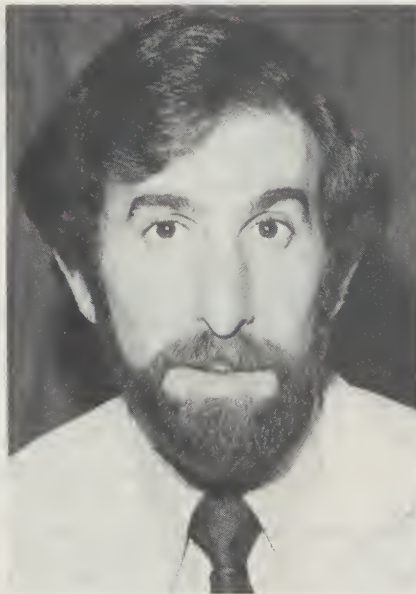
Dr. Milner Named

The appointment of **Sheldon Milner, MD** as Chief of the newly formed Division of Oncology at Lutheran Hospital of Maryland, Inc., has been announced by **Herbert Kushner, MD** Chief of Medicine.

"By providing care to cancer patients, the new division adds

another component to inpatient care capabilities," Dr. Kushner said.

In addition to his responsibilities for inpatient oncology services, Dr. Milner will be directing the Outpatient Program, which is for cancer patients well enough to be seen on an outpatient basis and is scheduled every Thursday

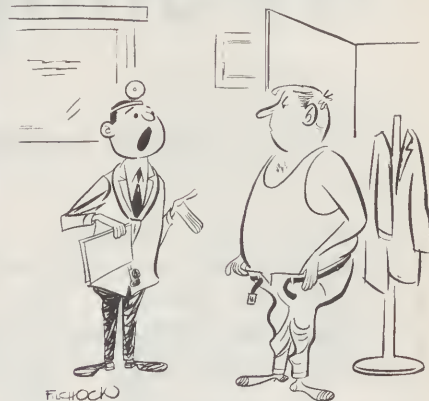


DR. MILNER

morning in the Hospital's Outpatient Care Center, located on Rayner Ave. near the corner of Ashburton St. in Baltimore.

Dr. Milner received his medical education at the University of Maryland School of Medicine. He interned and did his residency at the University of Maryland Hospital, and was a clinical assistant at the Baltimore Cancer Research Center.

The outpatient component of the oncology program is supported by a grant from the Morris Goldseker Foundation. □



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Oct. 11-13, Topics in Gastroenterology and Liver Disease: Medical and Surgical Aspects.

Oct. 18-26, 21st Annual Emil Novak Memorial Course in Gynecological Pathology, Cytogenetics and Endocrinology, in Conjunction with Intrauterine Development and Fetal Management.

Oct. 19, Community Strategies for the Care of the Chronically Ill.

Nov. 1-2, Ultrasound Quality Control Course.

Nov. 1-4, External Fixation: The Current State of the Art.

Nov. 5-14, Fiberoptic Bronchoscopy.

Nov. 7-9, Office Management of Chronic Pain.

Nov. 15-17, Sexually Transmitted Diseases: An Update.

Nov. 16-17, Progress in Pediatrics: 1979.

Nov. 29-30, Chronic Disease Epidemiology at the Threshold of a New Decade: A Symposium in Honor of Dr. Abraham M. Lilienfeld.

Dec. 1-2, Surgical Management of Intracranial Aneurysms.

Dec. 1, 7th Annual Geriatrics Symposium.

Dec. 2-4, Lactose Absorption.

Georgetown University Medical School

For details, call **Dr. Dean Schuyler**, (202) 625-7354. All talks Rm. LA-2, Basic Science Bldg., GU Med. Campus, 3800 Reservoir Rd., NW, Wash., DC 20007.

Dec. 7, 1-4:15 PM, Understanding and Treating Sexual Impotence, Paul Fink, MD. (Philadelphia), 3 hrs., Cat. 1 cred.

Dec. 19, 8-10 PM, Endorphins: The Brain's Own Morphine, Solomon Snyder, MD. (Baltimore, Maryland), 2 hrs., Cat. 1 cred.

Other Maryland Meetings

Oct. 13, Topics in Cardiovascular Disease for the Family Physician, cosponsored by the Amer. Heart Assn. Central MD Chap. in conjunction w/ the Anl. Mtg. of the Amer. Heart Assn. MD Affiliate, Inc., Hunt Valley Inn, MD Rm. 4, Hunt Valley, MD. For details on this all-day session, call **Sue Dagurt** at (301) 685-7074.

Oct. 17-19, Consensus Development Con. On The Use of Microprocessor-Based "Intelligent" Machines in Patient Care, Sponsored By National Institutes of Health Div. of Research Services at the Sheraton Silver Spring Motor Hotel, 8727 Colesville Rd., Silver Spring, MD. 20910. For additional info., contact **Henry S. Eden**, MD, Assistant to the Chief Biomedical Engineering and Instrumentation Branch, DRS Bldg. 13, Rm. 3W13, National Institutes of Health, Bethesda, MD 20205: (301) 496-5771.

Persons who requested reprints of **Nursing Bottle Syndrome** by **Sol B. Love**, DDS from the **March, 1979 Journal** prior to Sept. 1, 1979 and have not yet received them should please write **Dr. Love** at 204 N. Liberty St., Balto., MD 21201.

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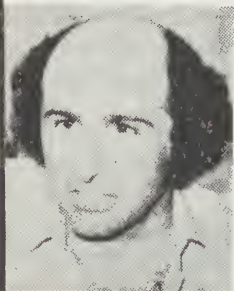
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Upper Gastrointestinal Bleeding,

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and

**Surgical Treatment for Rheumatoid
Arthritis of the Hand,**

by Drs. Homer C. House and J.B. Desilva

Periodical Use by Med-Chi Members

A major function of the Faculty Library is to provide Faculty members with copies of periodical articles. One of the benefits of membership is the ability to receive up to 50 pages of photocopy each month at no charge. This means that each Faculty member is entitled to seven or eight articles each month. Members may request more than 50 pages in any one month, but are charged \$.10 per page for the amount over 50 pages. This privilege is not transferable from one Med-Chi member to another, or from a member of the Faculty to a physician who is **not** a member of the Faculty or from a member of the Faculty to an allied health worker or nurse. All requests for photocopied articles must be submitted in the name of a member physician and will be distributed to that member. Requests for photocopying may be submitted directly by telephone (only for requests for one to two articles) or mail or through the librarian at a hospital where the physician has privileges.

When a request is submitted through a hospital librarian, the articles will be sent to the hospital library for distribution to the requesting physician, unless the request specifies that the articles are to be sent directly to the physician. Med-Chi members who use the photocopy service are bound by the provisions of the US Copyright Law, Title 17, which permits an individual to procure one copy of a copyrighted article for his own use for educational, research or scientific purposes. The Faculty Library staff will not honor any request for photocopying that they believe to be in violation of the copyright law.

The Faculty Library fills photocopy requests from its own collection of nearly 1,000 periodical titles. In addition, it can obtain copies of articles from journals that it does not own through its cooperative activities with other health sciences libraries including those at the Johns Hopkins University, the University of Maryland and the National Library of Medicine. Between May, 1978-April, 1979, the Faculty Library filled more than 8,000 requests for photocopied articles from Med-Chi members; of these just over 2,000 had to be obtained from other libraries.

The fact that the Library now fills only 75% of members' requests from its own collection is a cause for alarm. In past years, the proportion has been somewhere between 90%-95%. This statistic means that now one-fourth of the members' photocopy requests take 10 days or longer to answer, while the Library tries to locate another library that has the needed periodical and then obtain a photocopy of the article through the mail. This situation also raises the specter of the Med-Chi Library's becoming too much of a burden on other libraries by relying upon them to fill some needs that it, itself, should be meeting.

In an effort to correct this situation and restore the balance to at least 90%, the staff of the Library has taken

a very careful look at the interlibrary loans requested for Med-Chi members over the past couple of years. These have been analyzed by the number of times each title was requested, the year in which each requested article was published and the number of individual members who requested that journal title. The study proved most revealing. The Faculty Library would be able to reduce the number of times it has to go to another library for an item it does not own by more than half if it were to add 50 journal subscriptions. The titles of these new journals would be those from which photocopies have been requested by the largest number of individuals and most often from other libraries.

However, acquiring 50 additional journal subscriptions is not that easy. The average price for a year's subscription to one of the 50 needed journals is \$70, and the Library is already spending all the income to its endowment funds for its present journal subscriptions and purchases of monographs.

Looking at the journal titles from which we request photocopies from other libraries is only half the story. The other half concerns the titles to which Med-Chi now subscribes, receives on exchange for the **Maryland State Medical Journal** or receives free that are not used by Med-Chi members.

After examining all the interlibrary loan requests from the past couple of years, the Library staff next examined the records of members' use of periodicals that belong to the Med-Chi Library. This was easier for this Library than for most other libraries because almost all the use of the Faculty Library is by mail and/or by telephone, with practically no walk-in use. As a result, the Library had documented records of every use made of its journal collection, usually in the form of a photocopy request submitted by a Med-Chi member to get a particular article.

By examining these request forms, the Library staff were able to determine which items are used the most by Faculty members and to record the years in which the requested articles were published. The major result of the study (a predictable result, according to the experience of other libraries) was to show that a large portion of the Faculty Library's collection of medical periodicals is not used by the membership and that a few very select items account for most of the use of its collection. It remains, then, to evaluate especially the titles for which there is no indication of use. This analysis would consider whether these titles are purchased by the Library on subscription, received in exchange for the **Maryland State Medical Journal** or are received as gifts. The mere fact that the Faculty does not have to pay for a particular title does not mean that it is cost-free; considerable staff time is spent in checking in journal issues, shelving them and preparing them for binding—and there is, of course, the cost of binding.

In order to allow for subscriptions to additional periodical titles that will be used by Faculty members, many unused titles will have to be dropped completely. Because they are not used by members, back volumes will be offered for sale to other libraries or discarded. Those journals that are received in exchange for the **Maryland State Medical Journal** will be evaluated in comparison with the subscription and mailing costs of the **Journal**. While many fine titles are received in exchange for our own **Journal**, others do not compare in value and represent merely a burden on both the publishing of the **Journal** and the Library. The exchange for these particular items will be dropped.

Finally, the policy of keeping all the materials which are given to the Library will be changed, and in cases in which a publication is not being used or is not relevant to the Library's collection, efforts will be made to have the Library removed from its mailing list and accumulated issues will be sold or discarded.

A further result of this study will be to evaluate the practice of binding all the Library's journals. If a particular journal is seldom used a year or two after it has been published, it is economically advantageous, and practical in terms of space, to purchase the publication on microfilm instead of binding it. The Library now owns a microfilm/microfiche reader-printer and could still provide copies of any article published in this medium.

All of this may seem very logical and make good sense from a business point of view, tempting some to wonder why it has not been done in the past. One reason is that in recent times there has been a drastic change in the philosophy of medical libraries. The library is increasingly being seen in its role of providing information instead of being a mere storehouse of information. Except for major national libraries, such as the National Library of Medicine, and major university libraries, such as the Countway Library at Harvard, it is impractical to expect a library to contain nearly everything that has ever been published on a particular subject. Space and budget limitations immediately restrict the Faculty Library from such a philosophy. A more realistic approach is to develop and maintain a library that can satisfy about 95% of the information requests that will be directed to it by Faculty members. The remaining 5% of these requests can always be obtained from other sources, such as the National Library of Medicine. This approach is in line with the purpose and function of the Faculty Library—to meet the medical information needs of the Faculty membership. Given the current rapid increase in the number of individual members making use of the Faculty Library each month and the increased demands being placed upon the Library by those who have used it in the past, this is the only approach to the philosophy of the Library that will allow it to function in an efficient and effective manner.

In the future, members should be able to expect even faster and better responses to their information requests, especially for photocopies of periodical articles. A list of all the new journal subscriptions added for 1980 will appear on a future **Library Page** of the **Journal**.

JOSEPH E. JENSEN
Librarian

Rare Medical Books and Histories of Medicine for Sale by the Faculty Library

The Faculty Library is publishing a list of rare medical books and other items related to the history of medicine that are available for sale. A new list comes out about once every two months. The items to be sold are duplicates from the Faculty's collection and materials that are donated to the Faculty Library and prove to be duplicates. Proceeds from these sales go to the support of the Faculty Library.

To get on the mailing list for these periodic lists, write or call me at the Faculty Library.

JOSEPH E. JENSEN
Librarian

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of August, 1979:

1. Literature reviews on anticoagulant therapy in pregnancy	16	Citations
2. Gastric bypass for obesity	18	"
3. Recurrence of tuberculosis	28	"
4. Use of hypnosis to control pain	27	"
5. Treatment of familial and primary amyloidosis	25	"
6. Reversing vasectomies	31	"
7. Dermatofibrosarcoma Protuberans	17	"
8. Learned helplessness	25	"
9. Alcoholism in rural America	21	"
10. Management of the patient with chronic pain	98	"

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library.

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Medical Miscellany

Hopkins Holds Symposium on Women Physicians

One-fourth of the 16,000 students entering medical school in the US this year will be women. They will join 38,000 women already in practice, about 10% of the nation's doctors.

What impact are they having on medicine as it is practiced in our society? How well are they fitting into a traditionally male bailiwick? How do they handle a career in one of the most exhausting and time-consuming professions in addition to the demands of their private lives?

These and other questions will be explored October 9-10, 1979 at The Mary Elizabeth Garrett Symposium on **Women Physicians in Contemporary Society**, to be held at the John Hopkins University School of Medicine in Baltimore. The 15-guest faculty will include Mary Ellen Avery, MD, Physician-in-Chief, Children's Hospital Medical Center, Boston; Leon Eisenberg, MD, Professor of Psychiatry, Harvard Medical School; Carola Eisenberg, MD, Dean for Student Affairs, Harvard College; Carolyn M. Elliott, PhD, Director, Center for Research for Women, Wellesley College; Lesley Stahl, CBS-TV news correspondent and Jeremiah Barondess, MD, Professor of Medicine, Cornell University Medical Center and immediate Past President of the American College of Physicians.

These distinguished guests and 17 faculty and staff members of the

Hopkins School of Medicine will discuss a variety of major issues, starting with a profile of women and men physicians who have graduated from Harvard Medical School between 1949-79: who they are, what they're doing, aspirations, frustrations and achievements.

Some of the other panels will examine the societal implications of the increasing number of women doctors; preceptions of women doctors by themselves, their colleagues, friends, patients and society; women physicians' choices and roles in professional and private life and the impact of women on national health policies.

The symposium is named after a woman who wasn't even an MD, but nearly 100 years ago, Mary Elizabeth Garrett and four determined female friends raised more than half a million dollars and fought considerable prejudice to help establish Johns Hopkins as the first school of medicine in the country that would admit women and men on equal terms.

Part of a country-wide movement to provide higher education for women, they seized the financial problems of the fledgling Johns Hopkins University as a way to advance the cause of women in medicine. Ms. Garrett gave \$354,000, and fundraising committees that included two president's wives contributed the rest. The \$500,000 endowment was offered only with the proviso that women be accepted on the same terms as men. The all-male University Board of Trustees reluctantly accepted the offer.

Since the first medical school class entered in 1893 with 15 men and three women, Hopkins graduates have included **Florence Sabin, MD**, first woman member of

the Rockefeller Institute for Medical Research and first woman elected to the National Academy of Sciences, and **Helen Brooke Taussig, MD**, "first lady of cardiology," who developed the famed blue-baby operation with Dr. **Alfred Blalock**.

A more recent well-known graduate will be on the symposium panels: **Caroline B. Thomas, MD**, who discovered that rheumatic fever could be prevented by use of sulfa drugs and has since become famous for her 30-year study of the relationship between health and personality in Hopkins School of Medicine graduates.

The symposium will be chaired by **Carol Johnson Johns, MD**, Associate Professor of Medicine at the Hopkins School of Medicine. An internationally known expert in chest disease, Dr. Johns was recently appointed Interim President of Wellesley College, MA.

"I believe this symposium will serve as a milestone and provide a guide for future directions for the maximal benefits for society and medicine with regard to women physicians," Dr. Johns says.

The symposium will be co-chaired by **Bernadine Bulkley, MD**, Associate Professor of Medicine, who directs the Coronary Care Unit at the Hopkins Hospital, and also chairs the affirmative action committee. □

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Shape Up For Life

Shape Up For Life is the American Medical Association's new nationwide campaign. The above logo, designed by Draper Daniels, Inc., Advertising, will appear on all campaign materials. It symbolizes the good feeling which comes from healthy living. Radio and television public service announcements will be airing this Fall to carry the message into homes throughout the country. A poster and pamphlet suitable for placing in doctors' offices, schools, churches, clinics, businesses and other public places are available through the Auxiliary.

The campaign is a two-year effort. The first phase, just getting underway, will concentrate on foods for fitness. The second phase, to be introduced in July, 1980, will focus on physician fitness. The whole program will be directed by the national Health Projects Committee. Its aim is to 1) inform Americas that proper nutrition and exercise are vital to good health and fitness and 2) make them aware of what they can do for themselves to keep healthy. This is the Auxiliary's contribution to the health care industry's Voluntary Effort for cost containment.

Philip White, ScD, Director of the AMA Department of Foods and Nutrition, spoke to Auxiliary delegates at the annual convention in Chicago last July about nutrition in this country. To combat the misinformation and distortions about food and health, he suggests an all-out offensive to establish the positive values. Health and vitality are the dividends of good nutrition. Even though these qualities are good in this country, they are not what they should be. The basic problem seems to be lack of concern about good nutrition rather than lack of information or education on the part of our citizens.

The greatest nutritional problem in this country is obesity, due mostly to overindulgence and lack of exercise. We need to provide a better environment for health. Emphasis on prevention rather than treatment of obesity could be a step in that direction.

There is no such thing as an American diet. We have a wide variety of food patterns and practices. The problem is that the variety is too limited, i.e., the only vegetable many people seem to eat is the potato.

A survey being conducted by the US Department of Agriculture shows that women seem to be subsisting on a caloric intake just above the amount needed for basal metabolism. If these women are healthy, then they have to be extremely inactive, or all the research done on caloric requirement is in error. This is a form of malnutrition, meaning bad nutrition, not deficiencies, but continued bad nutrition can lead to deficiencies. The concept of good nutrition as set forth by the AMA, and now before the House of Delegates for policy acceptance, stresses variety, moderation and constraint. There is no need for the large amounts of vitamins and miner-

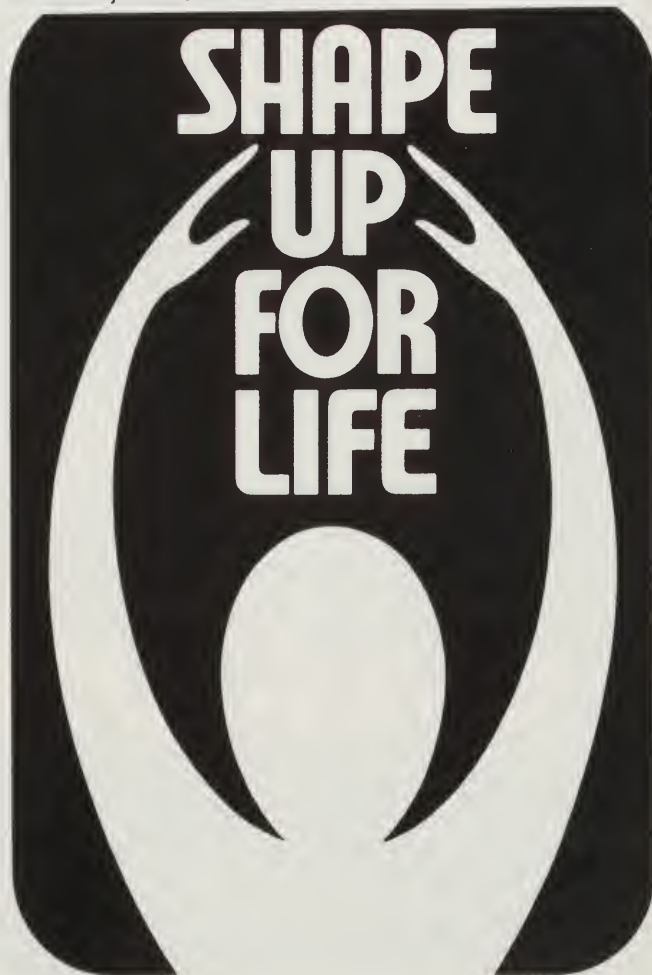
als in dietary supplements. Adequate diet and food intake are more than sufficient to provide nutritional needs. If a supplement is needed, it should be given only under the supervision of a professional person.

It is most important that poor nutritional habits observed in children be corrected immediately. If not, they tend to carry over into adulthood and are very difficult to overcome. Our efforts should be concentrated on our youth. Present the idea to families and communities that good nutritional habits and good physical activity are as important as love and education for our children.

In summary, Dr. White said that nutrition and exercise are inseparable. There is no known combination of foods that will correct problems caused by inactivity. Also, no one food can be judged except as it relates to the whole dietary program. This is why variety is stressed so that we are not dependent on a given food.

A positive personal, family and community image in fitness and health is essential. That means good nutrition. Shape Up For Life and manifest health, vitality and productivity!

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression. Changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES, Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
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Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, J.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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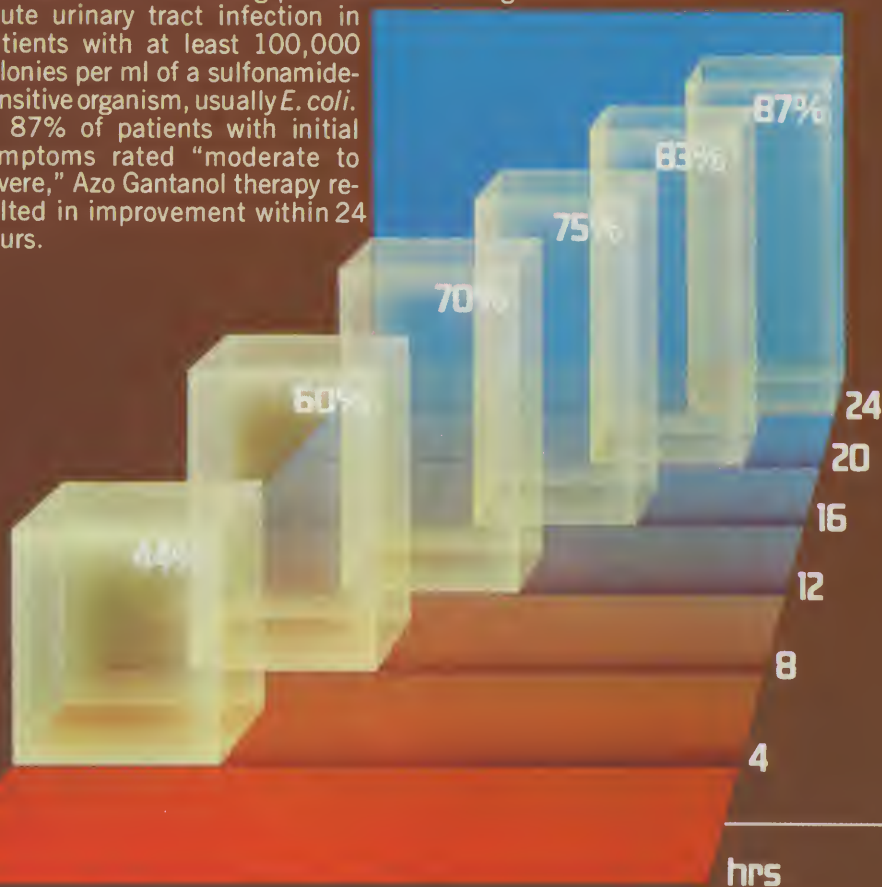


For prescribing information see opposite page.

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A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



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Before prescribing, please consult complete product information, a summary of which follows. **Indications:** In adults, urinary tract infection complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Not:** fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms may reduce the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels; variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatic uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused instances of goiter production, diuresis and glycemia. Cross-sensitivity with these agents exists.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. **Usual adult dosage:** 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists after relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) should be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine. **Supplied:** Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

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Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity, acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL. Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication, abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

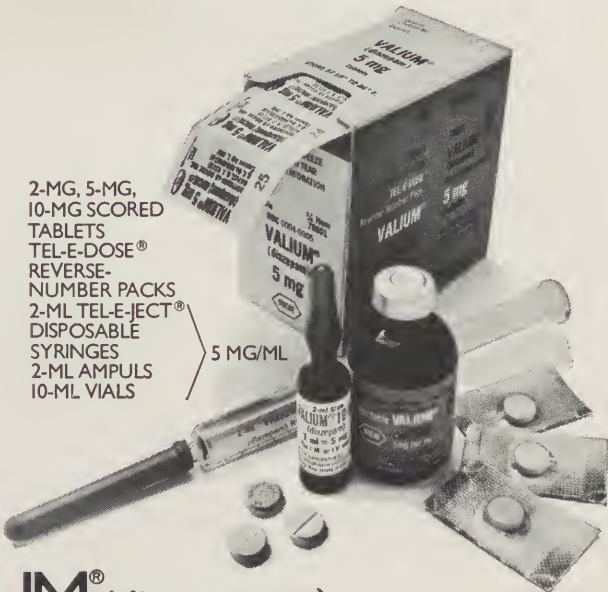
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, IV fluids, adequate airway. Use levetiracetam or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose* (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10, Vials, 10 ml, boxes of 1; Tel-E-Ject* (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



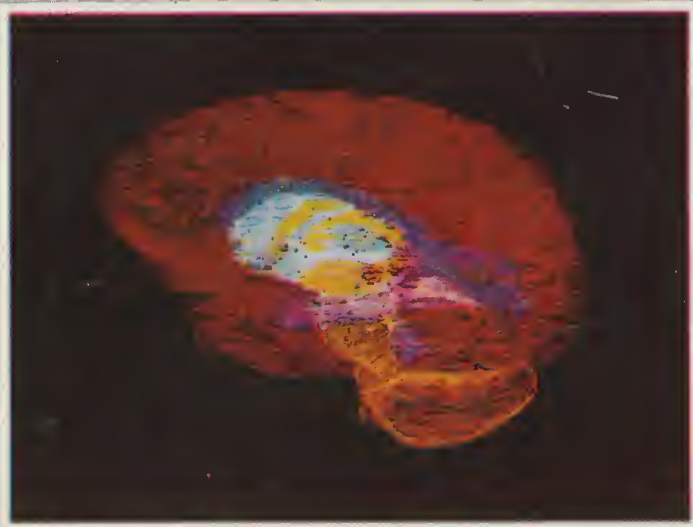
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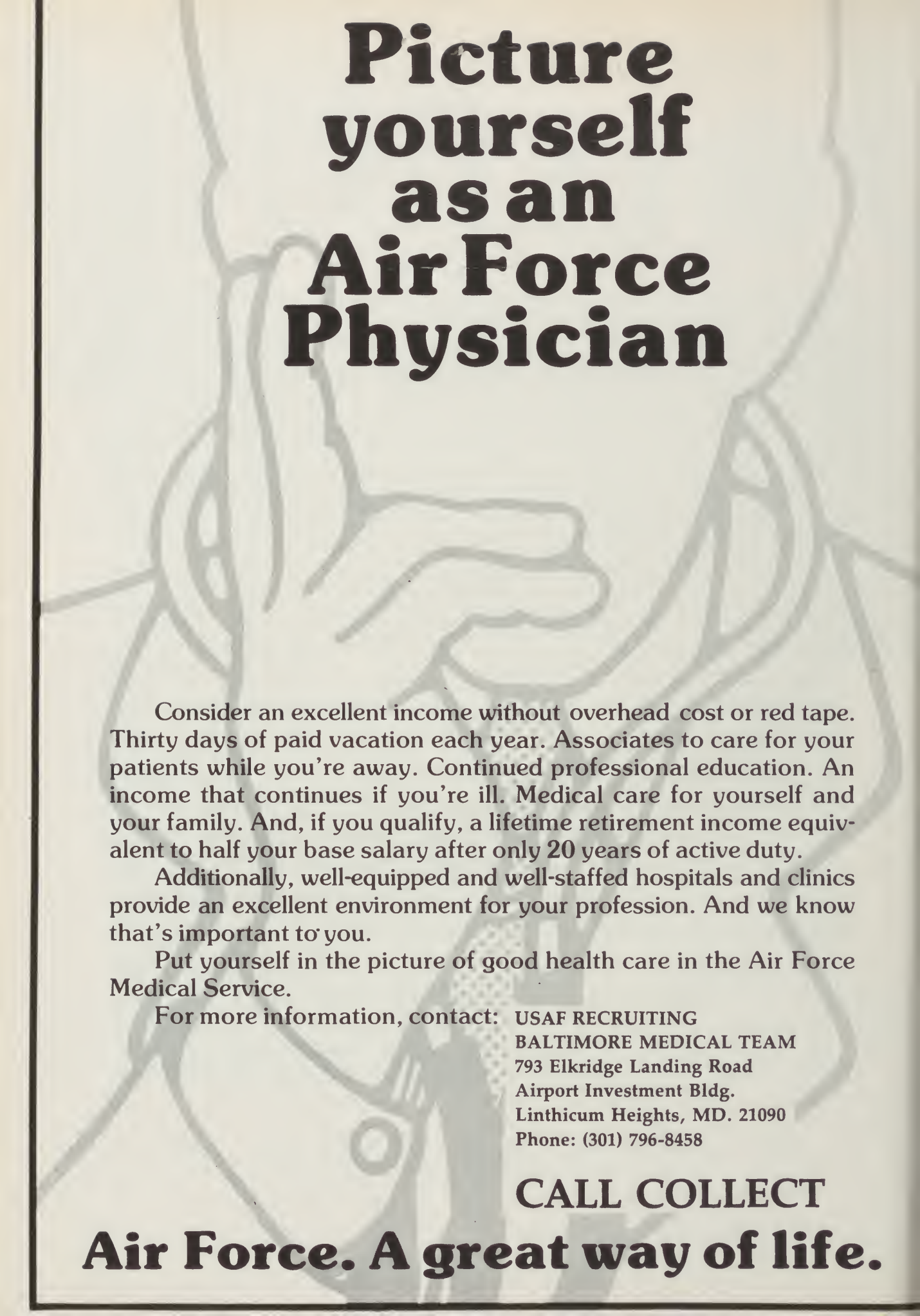


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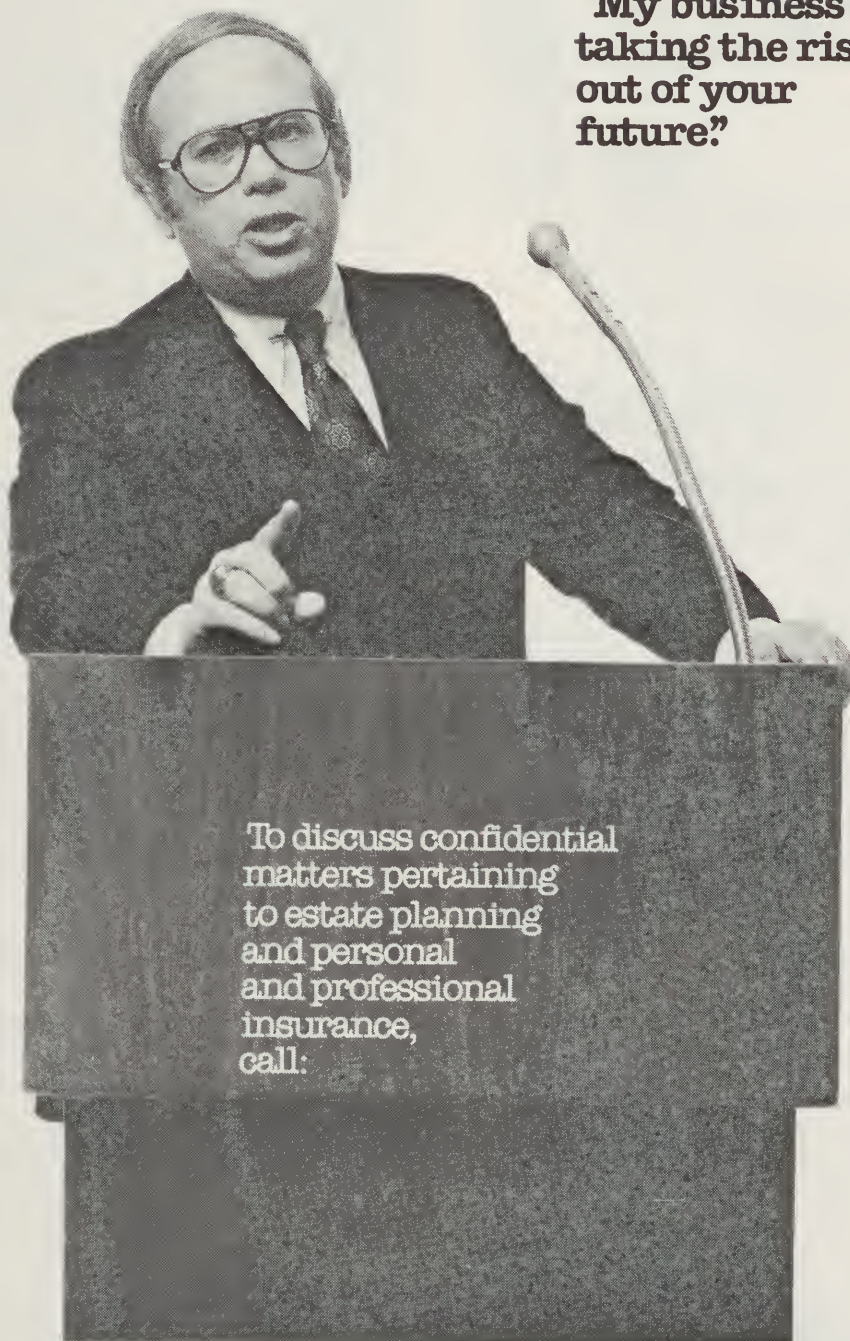
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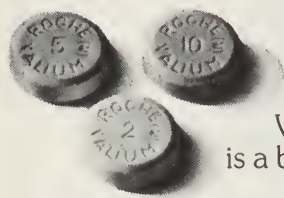


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Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active diazepam as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

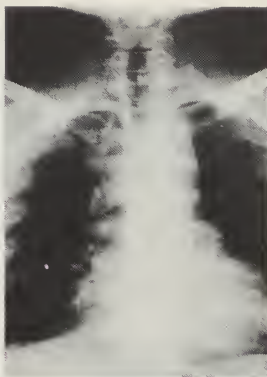


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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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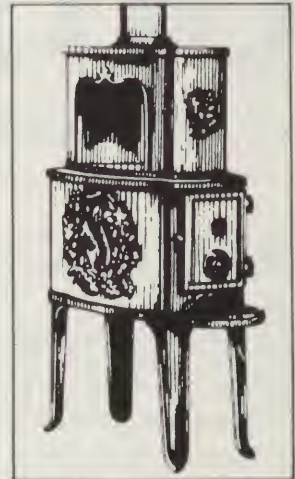
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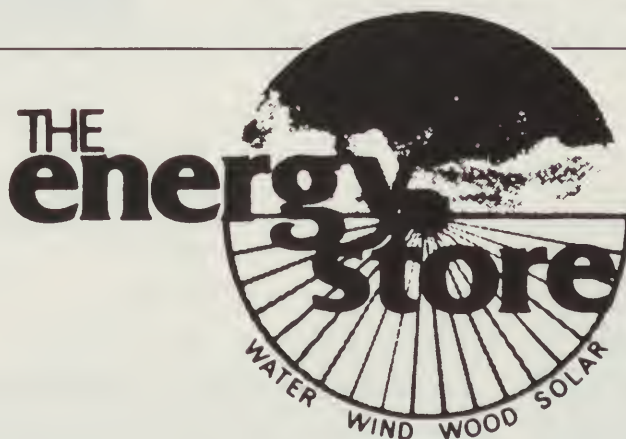
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Primary Alcoholism Treatment Program

By SANDRA HATHAWAY-HILL, R.N. and L.R. ALLEN

Ms. Hathaway-Hill is Director of the Primary Alcoholism Treatment Program, 1105 E. Fayette St., Baltimore, MD and Mr. Allen resides at 5254 Pine Bark Ct., Columbia, MD 21045. Contact Ms. Hathaway-Hill for reprint and other data.

•

The Primary Alcoholism Treatment Program (PATP) is designed to provide service to indigent alcoholics on a large scale, cost-effective, community-based setting. The building is located at 1105 E. Fayette St. Baltimore. This is one and one-half blocks from one of Baltimore's "skid row" areas, is also near the waterfront and surrounded by several large urban renewal housing projects. This setting makes the program within easy access of the inner city hospitals, mental health clinics, other alcohol and drug abuse programs, the police and community at-large.

The program components include medical transportation and street rescue, screening and evaluation, short-term observation, referral counseling, inpatient detoxification services, individual and group counseling, aftercare planning and follow-up. These services are provided 24 hours per day, seven days per week by a staff of professionals and para-professionals with three Medical Doctors on contract who make daily rounds through the facility. Patients are received in the facility from a variety of sources. The majority (approximately 38%) are referrals from hospitals, social welfare organizations or other community programs. Some 30% are self-referrals (walk-ins). Approximately 17% are brought in by police, and another 15% are brought in by the program's own street rescue unit, known as "Project Good Samaritan." The street rescue unit also responds to requests from the police.

The facility has a total of 32 beds and can accommodate both male and female patients. The average daily patient load is 34, so they are often operating at capacity or better. The average patient length of stay is five-six days. In Fiscal Year 1978 there were 6,750 units of service provided by the program. This figure, using one year's data, includes initial visits as well as return visits by the patients; 63.35% or 1,689 patients out of 2,666, did not return after their first visit. Some 878 patients made from two to 10 visits to the program. This represents approximately 32.9%, while one individual made as many as 46 visits to the program during the year.

The current patient mix reflects both the skid row population as well as the community in which the program is located.

All patients who present themselves for care are medically screened and encouraged to accept medical detoxification when appropriate. If acutely intoxicated, the patient is placed in a protected environment, a

short-term observation unit under medical supervision, until sober enough to be admitted to the medical unit. The majority of the patients put in the short-term observation unit are referred by the police.

Patients determined in need of medical detoxification, or who are in distress from the effects of chronic alcoholism, are admitted to the PAT Unit. They receive compassionate, non-judgmental care by a team made up of both medical and counseling staff. The patient is given a thorough medical evaluation and medication to help relieve the pain of the alcohol-withdrawal syndrome. While the patient is under medical review, an effort is made to consolidate medical treatment and to involve him/her in the appropriate resource for the patient's continuing medical care, thus providing a source for consolidation of treatment and of records of medical treatment.

Patient care is coordinated by the medical and counseling staff with patient participation to develop a treatment plan which will be most beneficial. This includes an aftercare plan with a follow-up record. The patient is given differing degrees of responsibility for follow-up reporting. Treatment plans are written into the client's permanent records, spelling out the method by which the program staff will provide support to assist the patient in aftercare plans.

Patients who are not in need of immediate acute medical care, or who do not wish and/or need detoxification, are offered the benefit of counseling to develop a treatment plan. When a plan has been agreed upon by both patient and counselor, disposition is made. In cases where the patients are to be referred to other treatment services, the counselor will arrange for the patients to be transported to the referral service as soon as possible. A request for follow-up information is sent to the treatment programs used as referral sources, and the follow-up information becomes a part of the patient's permanent record, thus allowing for better continuity of care should the person return to the PATP.

Another important element of the program is the "soup kitchen," which provides soup and sandwiches to the patients, or the "nutritional support," since it does provide the badly-needed nutrition to those who have been drinking and neglecting their diet.

This program is at the "hub" of the wheel of various community resources available to help the alcoholic recover. □

SEMIANNUAL MEETING DATES

Sept. 12-16, 1980 Baltimore Convention Center

The Open Forum

"Misperception"

I would like to take this opportunity to correct a misperception held by Dr. Sandra Z. Salan in her editorial comment on the article by Drs. Kushner, Richardson and Shilder, **Carotid Endarectomy in a Small Community Hospital: A Team Approach**, in your July, 1979 issue.

Dr. Jack Kushner, Board Certified in Neurology and Neurosurgery, was the surgical team leader in the cases presented, and Dr. Gary Richardson, a cardiovascular surgeon, his surgical assistant. Dr. Peter Shilder, a Board Certified Neurologist, saw each of these patients either as primary physician or on consultation. In all cases, each of these patients was seen by **all three** physicians.

Therefore, as these were the members of the team who worked together on **each** of the patients in the role as described above, the conclusion that "if-evenly-split, no surgeon did more than four of the procedures in that hospital per year" is misleading and inaccurate.

BARBARA A. MLYNCZAK, RN, BSN, CCRN
Patient Care Supervisor, ICU
Anne Arundel General Hospital
Annapolis, MD 21401.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of the State of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to the Physician Placement Service, 1211 Cathedral St., Baltimore, MD 21201; telephone 1-301-539-0872.

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

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1980 State Journal Conference To Be Held in Baltimore

The State Medical Journal Advertising Bureau, Inc.—whose membership comprises the 33 states (including Maryland) nationally that publish state medical journals—will hold its annual conference in Baltimore on Sept. 19-21, 1980 to coincide with the famed Baltimore City Fair, now in its 11th year.

The Conference Program Chairman will be **Journal** Managing Editor Blaine Taylor, who chaired the recent 1979 Conference at Goat Island, Newport, R.I. Taylor, 32, at the **Journal** since 1974, was also recently elected to the SMJAB Board of Directors as the only Managing Editor so serving.

The Newport SMJAB program included such renowned speakers as Dr. Arnold S. Relman, Editor of the **New England Journal of Medicine**; David A. E. Shephard, MD, President-Elect of the American Medical Writers Association; Dr. Stanley M. Aronson, Dean of the Brown University School of Medicine; Fred Fabro, MD, Editor of **Connecticut Medicine**; Victor S. Falk, MD, Editor of the **Wisconsin Medical Journal**; Gerold L. Schiebler, MD, Editor of the **Journal of the Florida Medical Association**, as well as various non-MD Assistant and Managing Editors from different states.

The 1980 meeting marks the first time the SMJAB group has met in Baltimore.

AN EXTENSION OF HOPE FOR THE ALCOHOLIC

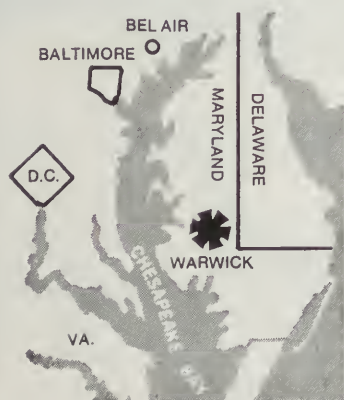


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In Memoriam: Carol Conners Broaddus, 1919-79

President, Auxiliary to the Medical
and Chirurgical Faculty of Maryland, 1977-78

It's almost impossible to realize that less than three months ago our beloved Carol Broaddus was a healthy and vigorous woman. She died of cancer in the early morning hours of Aug. 8, 1979 at the Johns Hopkins Hospital.

Carol was a native of Shaker Heights, OH. She received her bachelor's degree in biology from Duke University and her master's degree in biochemistry at the Case Western Reserve University School of Medicine.

Her husband, Dr. Robert E. Broaddus, whom she married in 1943, has a private psychiatric practice in Havre de Grace, MD. Dr. Broaddus was formerly with the US Army Medical Corps.

Besides her husband, she is survived by four sons, Robert Eugene of London, England; James Conners of New York, John Hale of Grand Rapids, MI and William Clendenin of Cleveland, OH; one daughter, Julia Anna of Romney, WV; one sister, Eileen Becker of Cleveland Heights, OH and two granddaughters.

The above vital statistics do not tell the kind of woman Carol was, or the quality of life she led. God endowed Carol with a brilliant mind, many talents and boundless energy. She used them all unstintingly for the benefit of others. Carol was a natural leader and organizer because she had keen insight and confidence in those with whom she worked.

Bob and Carol were a devoted and loving team. They supported each other in all undertakings. When they were separated because of Bob's overseas duty, Carol was the strength, stability and guiding light for him and their children. During one of Bob's tours of duty, they spent three years in Korea where Carol helped to found the Korean-American student exchange program and also the Korean Red Cross Volunteers. Throughout Bob's Army career, Carol was active in Officers' Wives' Clubs and other organizations pertinent to the service. While stationed at the Aberdeen Proving Grounds, Carol served as President of the Officers' Wives' Club and was instrumental in founding that group's scholarship for military dependants at Harford Community College, where she also taught microbiology in 1976. She had served as President of the Retired Officers' Wives' Club in Harford County and was President-Elect of that group at the time of her death. Carol served three terms as President of the Auxiliary to the Harford County Medical Society. During her tenure, she established immunization and cardiopulmonary resuscitation programs and worked in fundraising for AMA-ERF and the Health Careers' Scholarship fund at the local community college. As a lasting tribute to Carol, the Auxiliary to the Harford County Medical Society is renaming the Health Careers' Scholarship "The Carol Conners Broaddus Scholarship." At the National Convention, in July, Harford

County received the AMA-ERF award for the largest contribution per capita of the counties in the Eastern Region. This award is another tribute to Carol's enthusiasm and efforts.

When Carol began to work with the Auxiliary on the state level, everyone knew she would soon become our President. She served the Auxiliary in many capacities, from County to State President, and the job was always done in her quiet, unassuming manner. Carol firmly believed that all physicians' wives should belong to the Auxiliary and encouraged them to join and participate in its activities.

Carol Broaddus never met a stranger—there was always that big smile and sincere greeting to young and old, friend or stranger. She had great love for all people and a deep sensitivity for their feelings. These qualities would not permit her to do or say anything unkind. She abhorred gossip and saw only the redeeming qualities in her friends and associates. Carol could be firm, if neces-



MRS. BROADDUS
Photo by Judy Buck.

sary, but this was always tempered with gentle understanding.

Carol faced her final months of life as she had lived—patient, uncomplaining and with more concern for her family and friends than for herself. At the end, she was with her beloved Bob and their devoted children. This dear, gentle lady had a short, but wonderful, life and those of us whose lives she touched shall never forget her and will always remember her with love.

MRS. W. A. COUNCILL, JR. (MARIE)
Harford County Auxiliary



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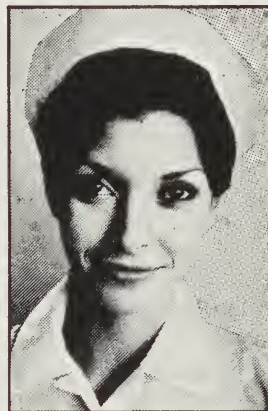
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JOHN SARGEANT, CAE, Executive Director

Executive Committee

The Executive Committee met on Sept. 6, 1979 and took the following actions:

1. Heard a presentation from Lou Orsini of the Health Insurance Association of American, regarding a proposal of the Maryland Health Care Coalition, with respect to review of quality in-patient hospital care and suggested he speak to the Council in this regard.

2. Heard a report from one of the Faculty representatives of the Maryland Hospital Association's Task Force on the same subject (quality of inpatient hospital care) and requested the three Faculty representatives be present at the same Council session, Sept. 29, 1979, to make a progress report in this area.

3. Determined that the above subject would be discussed in depth at the October Executive session with a view towards establishing some policy in this area.

4. Requested the Program and Arrangements Committee to designate some portion of the 1980 Annual Meeting to honor Nobel Prize Winners David Nathans, MD and Hamilton O. Smith, MD.

5. Submitted the name of Frederick O. Miltenberger, MD of Cumberland for another term on the statewide PSRO Council.

6. Adopted the House of Delegates Minutes of May 2 and 5, 1979.

7. Approved the location of the 1980 Annual Session and dates as follows: Baltimore Convention Center, Apr. 23-25, 1980.

8. Approved loan of some historical material for the month of October to the Baltimore Hebrew Congregation subject to the usual caveats in this regard.

9. Authorized attendance of two persons at the CME meeting in Chicago in October, 1979.

10. Approved purchase of a word processor as recommended by staff.

11. Approved 1980 Executive Committee meeting dates.

12. Declined to provide continued financial assistance to the son of a deceased physician because of lack of education progress.

13. In Executive Session, reviewed the Personnel Wage and Salary Study, but deferred final action until a later Executive Committee session. □

Council

The Council met on Sept. 29, 1979 and took the following actions:

1. Approved waiver of 1979 dues on account of illness for an individual member at the request of the component society.

2. Established 1980 Council meeting dates.

3. Urged Council members to submit nominees for various AMA Councils and Committees, as well as for the AMA Awards that are presented at the Annual 1980 Meeting of the AMA House of Delegates.

4. Agreed to cosponsor a Seminar on Risk Management with the Medical Mutual Liability Insurance Society.

5. By acclamation, approved support of Russell S. Fisher, MD as a candidate for a seat on the AMA Board of Trustees.

6. Deferred action on a proposed research study by the Montgomery County Maryland Medical Care Foundation that would look into physician job satisfaction.

7. Accepted two portraits from individuals in Maryland; one of Daniel Coit Gilman, and the other of Reverdy M. Hall, MD, first black physician to be admitted to membership in the Faculty in 18

8. Referred to the Executive Committee a question dealing with some written document that would specifically state the Workmen's Compensation Fee Guide is that, and not a fixed schedule of fees. Legal counsel will be brought into this discussion and a report made to a future Council session.

9. Deferred for further information the question of financial assistance being given to a proposed Seminar on Women in Medicine to be presented in 1980 at the University of Maryland School of Medicine.

10. Learned of the success of a corporate visitation program being conducted by Council Chairman and the President who are discussing with business and industry questions these groups have on health care and the costs related thereto.

11. Referred to the Executive Committee the question of provision of legal defense funds for physicians when acting in areas of peer review, fee review and ethics and from which suit is entered against the individuals and the components and requested a report to the November, 1979 Council meeting.

12. Received a report of the Ad Hoc Committee on HMOs, the full text of which is printed herewith. Took action by referral of Recommendations Two and Four to legal counsel for advice; referral of Recommendation Three to the Ad Hoc Committee for clarification; referral of recommendation Five to the Peer Review Committee for its consideration and action if deemed necessary; referral of Recommendation Seven to the Legislative Committee for implementation; referral of Recommendation Eight to the Public Relations Committee for review and recommendation, together with costs of such action.

13. Deferred action on a request of the Maryland Health Care Coalition in connection with concurrent review of hospitalized patients; pending receipt of the final report of the Maryland Hospital Association Task Force on Quality Patient Care, which is reviewing mechanisms to assure Quality Assurance for in-hospital patients. The Executive Committee plans to consider this at some length at its October, 1979 meeting, the Council was advised.

Report of Ad Hoc Committee on HMOs to Council

Information which has been gathered in the past

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few months by this Committee was reviewed and discussed, after which it was agreed a draft of a report to be made to Council would be prepared.

1. Having reviewed Federal and State statutes covering HMOs, it seems that Maryland's law is very nearly a carbon copy of the Federal statute and attempts to make changes in the statute at this time would be futile.

Recommendation: Physicians in Maryland should understand that HMOs are a fact of life, and do have a place in the various modalities of health care delivery. The Faculty took the following position in 1970:

The Faculty supports the concept that medical care can be delivered through various mechanisms, including closed panel programs; provided individual physicians render such health care on an equitable basis and further provided that the patient has the right to choose the mechanism through which he will receive such health care.

The Faculty's position on this matter should be reaffirmed.

2. One area of concern is the issue of advertising. The State Annotated Code provides that no HMO may be prevented from advertising its services or non-professional aspects of its operation, but cannot make any qualitative statements or misleading statements. For example, an HMO may make the statement, "We have a better plan," but it cannot state that it has better doctors. The Faculty's position on advertising in the past has been simply that physicians could not advertise except as defined by the Board of Medical Examiners. The Board has recently revised the regulations, and is awaiting the signature of the Secretary of Health and Mental Hygiene. These regulations will deal more specifically with ways the physician may advertise; however, the law dealing with HMOs permits advertising and even door-to-door solicitation which individual physicians are not permitted to do. Therefore, there may be a conflict between the State HMO law and regulations of the Board of Medical Examiners.

Recommendation: Legal counsel should be directed to study both the HMO laws (Federal and State) and the proposed regulations of the Board of Medical Examiners to determine whether there is direct conflict between how a physician in private practice may advertise and how an HMO may advertise on behalf of individual physicians.

3. The Committee expressed concern that patients enrolled in HMOs may sometimes be either confused or actually misled about the level of care they are receiving. That is, more extensive use of para-professionals is made in HMO's than in private physicians' offices. In addition, they are not always aware of the range of benefits being offered.

Recommendation: Some attempt should be made to require HMOs, when advertising their services, to let the prospective patients know that part of their care might be delivered by a Physician Assistant, Nurse Practitioner, etc. rather than a physician. This may or may not reflect on the quality of care given the patient, but in any case, the patient should have knowledge of who will render the care. In addition, prospective patients should be made aware of what services they are entitled to; i.e., emergency services are sometimes available only

with prior approval. Furthermore, the Maryland General Assembly passed a bill in the last session which would allow insurance carriers to offer hospitalization only as an option in prepaid plans. Full range of benefits is therefore not always included in HMO contracts.

4. Every employer with 25 or more employees must give employees the option of joining an HMO as part of its health benefits. This gives the HMO the healthiest segment of the population from which to draw its patients. This, of course, results in more favorable statistics for the HMO. Since contractual arrangements with HMOs are almost always with groups, it naturally follows that relatively healthy, employed people will comprise the largest number of members of any HMO; however, this Committee is concerned that the portion of the population most in need of care may still be neglected.

Recommendation: While the law states that HMOs must offer services to all segments of the population, it is doubtful that that segment most in need of such care is very actively solicited. A period of open enrollment, well-publicized, should be required through an amendment to State law if necessary.

5. The Committee was also concerned about the quality of care within the HMO. While Federal and State law require a monitoring mechanism for quality assurance, there is really no assurance that such a mechanism is in place or that it is effective.

Recommendation: That the Faculty take some action, possibly through its Peer Review Committees, to investigate the means by which such monitoring of care is accomplished.

6. In discussion with a Blue Cross representative who attended one of the Committee meetings, it was learned that statistics to date indicate that not more than 20% of the population has turned to HMOs for their care. This would be about the maximum that can be expected. Blue Cross has assured us that they feel it is essential to participate in the insurance of this 20% of the population. They are fiduciary advisors, but they are not subsidizing any part of the HMOs, although they do the marketing of certain HMO plans. We have no recommendation to make in this area.

7. It was also noted that Federal funding is available to underwrite new HMOs in the formative stages. This indicates unfair competition with other health care programs. Additionally, a problem is presented if an HMO goes bankrupt. Who pays for services for preexisting conditions? The Blue Cross representative who met the the Committee assured us that Blue Cross would become responsible for the bills for services rendered and coverage reverts back to Blue Cross so that the patient does not lose anything; however, there is no such assurance from other fiduciary agents.

Recommendation: A proposal should be submitted to the Legislature that every HMO established with Federal or State funding be required to share in establishing a reserve fund for the purpose of continuing care for those recipients who are left without coverage in the event of bankruptcy of the HMO. This fund could be established with a certain percentage of gross receipts from each HMO each year.

8. IPAs (Independent Practice Associations) is an option that is open to physicians. Members should be

warned about the financial dangers of such an arrangement since several HMOs are at present in financial difficulty. If HMOs are the wave of the future, we should encourage members of the Faculty to look closely at this mode of practice, be forewarned that it is fraught with danger and restricted by many regulations, but that they should also consider HMOs and IPAs as one mode of practice.

Recommendation: The strongest recommendation of this Committee is to put forth an educational program directed at physicians and the public alike, preferably by professional public relations people, emphasizing the fact that the Faculty supports various modalities of delivery of health care. All types of health care delivery should be discussed, including the advantages and disadvantages of each. In addition, although it has been said many times before, physicians must be told over and over again that they are their own best public relations agents and each physician must polish his own capabilities regardless of which mode of practice he chooses.

JOHN O. SHARRETT, MD
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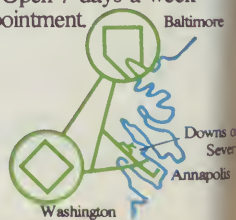
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Executive Director's Newsletter

November, 1979

ADVERTISING

The U.S. Medical Directory is again soliciting physicians with billheads indicating that physicians have appeared previously in the Directory, and urging that physicians complete the form for "the next edition."

ALERT

Members are warned that this is not an endorsed publication by any official organization and, in the opinion of knowledgeable persons, is not of any real value to physicians who may wish to be listed in this publication.

REGULATIONS'

REVISIONS

The Board of Medical Examiners is currently involved in the final draft of regulations governing advertising and solicitation by physicians. After approval by the Board, they will be published in the Maryland Register, a public hearing held and comments received, and finally approved by the Secretary of the Department of Health and Mental Hygiene. All physicians will be kept fully informed as these go through the regulatory process.

In other developments, the status of nurse specialists' regulations is as follows:

Nurse/Anesthetist: Amended and adopted.

Nurse/Midwife: Changed with a substantive amendment and re-scheduled for an additional hearing on Wednesday, November 21, 1979 at the State Office Building, starting at 1:30 PM.

Nurse/Practitioner: Awaiting action by the Secretary of Department.

AMPHETAMINE

REGULATIONS

The state regulations governing the prescribing of amphetamines have recently been revised. This class of drug may only be prescribed for narcolepsy, hyperkinesis or minimal brain damage. Prescription for any other condition must have an authorization number from the Medical Consultant of the Department of Health and Mental Hygiene. Requests for exceptions should be addressed to Sidney B. Seidman, MD, Medical Consultant, 1211 Cathedral Street, Baltimore, Maryland 21201. Full text of the regulations will be published in an early issue of the Maryland State Medical Journal, but a copy may be obtained from the Faculty office in the meantime.

MEMBERSHIP

We are again preparing to randomly survey 20% of our membership to determine your feelings on our work and the benefits offered to you, the members. We cannot urge you strongly enough to complete and return the survey, so we can be more responsive to your needs.

SURVEY

REVISED

MEDICOLEGAL

CODE

The Medicolegal Committee anticipates completion of revisions to the Medicolegal Code of Cooperation by the end of the year. The revised Code will provide guidance to doctors and lawyers on the problems most common to members of the medical/legal community, particularly in regard to requests for medical reports and information, and payment of bills for medical reports. Additionally, the Committee is planning a series of programs on current medical/legal issues, based on the needs and concerns of both professions. The programs are now being developed and will be presented by the Committee or in cosponsorship with other appropriate groups at some future date.

RESOLUTIONS

DEADLINE

Deadline date for receipt of resolutions for consideration at the 1980 annual House of Delegates session is

FRIDAY, FEBRUARY 29, 1980.

Receipt in the Faculty office must be by close of business on that date.

NEW

BOOKLET

In response to increasing inquiries regarding ownership, availability, and rights to review patient medical records, the Faculty has prepared a booklet outlining current legal and ethical requirements in this regard.

Copies may be obtained by contacting the Faculty office, 301-539-0872.

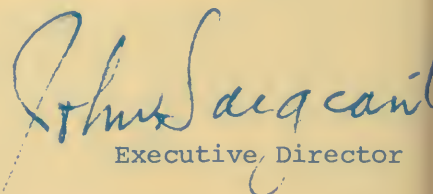
150TH

ANNIVERSARY

OF FACULTY

LIBRARY

The Library and History Committee is planning an appropriate celebration for the 150th anniversary of the founding of the Faculty Library in June of 1980. The June issue of the Journal will be devoted to a history of the library between 1830 and 1980. In addition, the library has recently received several significant donations. The contributions have come, both in the form of cash donations and rare medical books. Where the donated books duplicate those in the Faculty's collection, they are being sold and additional items purchased in the name of the donor. Further contributions are welcome and encouraged.


Executive Director

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**182ND ANNUAL MEETING
MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND**

**NEW DATES: WEDNESDAY, THURSDAY, FRIDAY,
APR. 23 - 25, 1980**

**NEW LOCATION: BALTIMORE
CONVENTION CENTER**

THEME: UPGRADING YOUR PRACTICE

Among the groups cosponsoring sessions at the Annual Meeting are:

- Committee on Alcoholism
- Maryland-DC Society of Rehabilitation Medicine
- Maryland Orthopedic Society
- John Staige Davis Society of Plastic Surgeons of Maryland
- Maryland Radiological Society
- Maryland Society of Allergy
- Maryland Ophthalmological Society/Maryland Academy of Ophthalmology
- Maryland Dermatological Society
- Public Relations Committee
- Committee on Physician Rehabilitation
- Occupational Health Committee
- Maryland Psychiatric Society
- Maryland Society of Gastrointestinal Endoscopy
- Maryland Society of Cardiology

•

The above program is subject to change. Watch for further details in upcoming issues of the **Journal**.

•

Business Sessions

Health Evaluation Tests

**Presidential Reception
and Banquet**

**Lunch and Learn Session
MMPAC Luncheon
Scientific and
Technical Exhibits**

**Auxiliary Activities
Scientific Sessions**

**Hospitality Night
Prayer Breakfast
Exhibitor Sweepstakes**

•

Plans are underway for Med-Chi's biggest and best Annual Meeting, which will be held in the beautiful, new Baltimore Convention Center, at Pratt and Sharp Sts. in the exciting Baltimore Inner Harbor. **PARKING IS AVAILABLE NEARBY . . . DETAILS TO FOLLOW IN UPCOMING ISSUES OF THE JOURNAL.**

Mark the dates on your calendar NOW: Wednesday, Thursday, Friday, Apr. 23, 24, 25, 1980.

WILLIAM A. PILLSBURY, MD, President
EMIDIO A. BIANCO, MD, Chairman
Committee on Program and Arrangements



182nd Annual Meeting
**MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND**
APR. 23-25, 1980

BALTIMORE CONVENTION CENTER, BALTIMORE, MD



SCIENTIFIC EXHIBIT APPLICATION

Scientific exhibits are an integral part of the Annual Meeting. All physicians, medical institutions, and organizations having an appropriate exhibit are urged to complete the application below for consideration by the Exhibit Subcommittee.

PLEASE INDICATE THE CATEGORY OF EXHIBIT:

- ☐ **SCIENTIFIC EXHIBIT:** Result of original scientific research which involved the personal contribution of the exhibitor. Its purpose is to advance medical knowledge. It should not be designed for the personal, financial gain of the exhibitor.
EXHIBIT FEE: Waived. Each Space 8' x 10'.
- ☐ **CLINICAL DISPLAY EXHIBIT:** Must be of a scientific nature, but not necessarily original research. The exhibitor need not be personally involved in the research. The exhibit should contribute to the advancement of knowledge of other members of the profession, but it may also contribute to the personal, financial gain of the exhibitor.
EXHIBIT FEE: \$150 for each 8' by 10' space.
- ☐ **EDUCATIONAL:** Any exhibit of a scientific and non-commercial nature which does not fit into either of the above two categories. Included would be voluntary health organizations and local and State agencies.
EXHIBIT FEE: \$60 for each 8' by 10' space.

PLEASE COMPLETE AND SUBMIT BY JAN. 31, 1980

Chairman, Subcommittee on Exhibits
Med-Chi
1211 Cathedral St.
Baltimore, MD 21201

DATE SUBMITTED

TITLE OF EXHIBIT

NAME AND PROFESSIONAL TITLE OF EXHIBITOR

EXHIBITOR'S ADDRESS TELEPHONE

STATE CITY ZIP

INSTITUTION PARTICIPATING IN EXHIBIT

AMOUNT OF SPACE REQUIRED WIDTH DEPTH HEIGHT

ANY SPECIAL REQUIREMENTS NOT COVERED IN THIS FORM

HAS EXHIBIT BEEN SHOWN AT OTHER MEDICAL MEETINGS?

PLEASE ATTACH A 50 WORD DESCRIPTION OF EXHIBIT.

RULES GOVERNING SCIENTIFIC EXHIBITS

1. U-Neek Display is the official decorator for the 1980 meeting, and, upon request, will transport, set up and dismantle an exhibit.
2. If the exhibitor elects to transport, and/or set up and dismantle his/her own exhibit, he/she is then fully responsible for his/her own exhibit.
3. The exhibitor is fully responsible for the content, arrangement and presentation of exhibit.
4. The Medical and Chirurgical Faculty will provide an 8' x 10' booth, back drop and side rails, one covered table and two chairs.
5. ALL ELECTRICAL OUTLETS will be billed directly to exhibitor from the Convention Center and should be ordered through U-Neek Display.
6. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS.
7. No reference to, or credit for, financial aid shall be shown on exhibit.
8. Only generic names may be used. No trade names are permissible.
9. Each exhibit should be manned at all times by someone familiar with its content.
10. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.
11. Inquires should be directed to:
Ms. Mary E. Galeckas at Med-Chi, (301) 539-0872.

In Praise of Hospital Libraries

With today's rapid growth in the volume of medical information, medical libraries have become more than luxurious monuments to the great past of medicine. The medical library is now the common ground between the physician who provides patient care and the universe of medical literature in which the latest modes of diagnosis and treatment are reported. As such, the medical library has become an essential component in the provision of patient care. One measure of the quality of care provided by an individual physician is the use he/she makes of current medical information.

The chapter on professional library services in the **Accreditation Manual** of the Joint Commission for the Accreditation of Hospitals illustrates the importance medical libraries have assumed. In order to receive accreditation, each hospital must provide library support for the information needs of its physicians and staff. The JCAH's principles and its interpretation require that these professional library services be supported by appropriate organization, staff and resources. Also, the library services must be guided by written policies and procedures. According to the JCAH, the hospital library is to have the same status as any other hospital department.

The concept of the importance of hospital medical libraries has been very slow to catch on. At the same time that the JCAH is becoming more concerned with hospital libraries, hospitals are facing pressure to contain, or even reduce, operating costs. Libraries are by no means inexpensive. One fact that is presented over and over again by hospital administrators, and even some physicians, is that Maryland's physicians have the resources of the Med-Chi Library—why does their hospital also need a library? The answer lies in the nature of the physician's information needs. Questions that arise concerning the treatment of patients usually need immediate answers. In most circumstances, if the information sought from a library is to have an effect on patient care, it must be readily available. The hospital library is needed both as an immediate source of health-related information regarding patient care and as a channel for efficiently and quickly obtaining such information from larger resource libraries.

What is more, physicians are not alone in being responsible for patient care; nurses and allied health professionals working in hospitals also have information needs. The Med-Chi Library is set up for, and supported by, the physicians of Maryland, and it does not actively collect resources regarding nursing care or allied health practice. Nurses and allied health practitioners do not have the same access to the Med-Chi Library that physicians do. The modern hospital library is a health sciences library, set up to provide for the information needs of **all** health professionals, not just the medical staff; however, hospital libraries face severe

limitations, both in budget and in space. Even the largest hospital library can only acquire a small proportion of the health-related publications that are available. In selecting publications for purchase, the hospital library must be guided by the needs of its clientele. Each item purchased must be carefully weighed in view of its value to the hospital's physicians and staff. Each hospital library's goal must be to obtain materials that satisfy the immediate needs of physicians and staff.

The hospital library is also the channel connecting the individual physician or health professional and the entire universe of medical information. Thus hospital libraries must be able not only to satisfy the immediate information needs of health professionals, but they must also be able to locate and acquire for their clientele virtually any publication related to health care that may be needed. When information is not available immediately, the hospital librarian may go to other hospital libraries, to a larger resource library such as the Faculty Library or to a university medical school library. If a resource library does not have the required material, the request can be channeled on to the National Library of Medicine; even it cannot make available every medically-related document, and so some requests may be sent on to still other national libraries, such as the British Lending Library.

In all this large informational network, the hospital librarian is the key. If an adequately trained library manager is available, a physician working out of the smallest hospital in Maryland has access to the same materials that are available to any physician practicing at a university medical center. The hospital library's trained manager is the gatekeeper who assures that the results of medical research are accessible to physicians and other health professionals who care for patients on a day-to-day basis.

As hospital libraries become better organized and developed, it is anticipated that the Faculty Library will gradually decrease its functions as a direct channel of medical information to physicians and will assume a supportive, backup role to hospital libraries. Evidence of this evolution can be found in the function Maryland hospital librarians are taking on by providing photocopies of journal articles to Med-Chi members. Most hospital librarians in Maryland are willing to do this, thus serving two purposes: first of all, there is a chance that the material may be available in the hospital library and the requester will not have to wait for it; secondly, it relieves the physician of the need to write or call the Faculty Library. He can stop in at the hospital library and make his request while the topic is on his/her mind, right after he/she has seen the patient.

The Faculty Library can also provide consultative services and support services in the way of acquiring, cataloging and processing of books, journals and au-

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diovisuals, leaving the individual hospital librarian free to work on the "firing line," answering questions and seeing that information is readily available. Because most hospital libraries will never be able to purchase more than essential journal subscriptions and essential reference texts, the Faculty Library will continue to be needed as a backup for other publications that contain needed information, but for which the need is not immediate. This will be especially true of materials needed to support continuing education programs offered by hospitals and materials needed by physicians preparing for specialty board examinations.

As Faculty Librarian, I have seen this trend developing over a long time. Hospital administrators are just beginning to realize that JCAH is now serious about hospital libraries. During the past two years, I have made numerous consultative visits to hospitals throughout Maryland, usually in response to requests by administrators for help to set up libraries to meet the JCAH requirements.

Hospital libraries in Maryland have come a long way in the last two years, but the process has not been easy. The concept of a library as a source of timely, current information—rather than as a storehouse of old books—is difficult to change, and yet the change has come. If you have not visited your hospital library in the last couple of years, it deserves a try.

These are exciting times to be a hospital librarian, as the challenge is great. Skill and insight are required to select for the library materials that will best answer most of the information needs of its clientele. The hospital librarian must know what resources are available in other sections of the hospital, as well as in the library. The librarian must also know what resources are available in other hospitals and in large resource libraries, as well as how to access these resources. All the medical research, and all the publications in which the results of this research are made public, are ultimately aimed at better patient care. The hospital librarian is the point of connection between medical research and the health care professional who must make practical application of the researcher's findings.

JOSEPH E. JENSEN

Librarian

□

Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of August, 1979:

1. Imipramine and congestive heart failure	39 Citations
2. Group purchasing for hospitals	16 "
3. Wilms' tumor and aniridia	10 "
4. Group therapy with chronically-ill patients	50 "
5. Real-time ultrasound for arterial vascular diseases	25 "
6. Alcoholism and acidosis	15 "
7. Lupus and the central nervous system	35 "
8. Techniques of hair transplantation	15 "
9. Use of anti-inflammatory agents for dysmenorrhea	24 "
10. Clonidine for drug withdrawals	19 "

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library. **ADAM S. SZCZEPANIAK, JR.**, Asst. Librarian

New Book Titles

Abdomen, Acute

- WI Cope, Zachary, Sir, 1881-
900 **Cope's Early Diagnosis of the Acute Abdomen.** 15th ed.
.C 782e New York, Oxford Univ. Press, 1979.
1979

Affective Disturbances

- WM Davis, John M.
171 **Psychobiology of Affective Disorders.** Kalamazoo, MI,
.D 262p Upjohn Co., 1978.
1978

Arrhythmia, Sinus

- WG Workshop on Sinus Node, Maastricht, 1977.
202 **The Sinus Node: Structure, Function and Clinical Rele-**
.W 928s **vance.** Boston, Nijhoff Medical Division, 1978.
1977

Asbestos

- ZWA Cancer Information Clearinghouse
754 **Asbestos and Health: an Annotated Bibliography of Pub-**
.C 215a **lic and Professional Education Materials.** Bethesda,
1978 MD, 1978.

Biofeedback

- WM **Biofeedback: Principles and Practice for Clinicians.** Bal-
420.3 timore, Williams and Wilkins, 1979.
.B 615
1979

Blood Gas Analysis

- QY Huber, Gary L.
450 **Arterial Blood Gas and Acid-Base Physiology.**
.H 877a Kalamazoo, MI, Upjohn Co., 1978.
1978

Delivery of Health Care

- W Mansinghka, Surendra K.
100 **National Health Insurance Issues: Viability of the Cost-**
.M 288n **Sharing Concept.** Nutley, NJ, Roche Laboratories, 1978.
1978

Dermatology

- WR Bluefarb, Samuel M.
100 **Dermatology.** Kalamazoo, MI, Upjohn Co., 1978
.B 658
1978

Diagnosis, Laboratory

- QY Widmann, Frances K., 1935-
4.3 **Clinical Interpretation of Laboratory Tests.** 8th ed.
.W 641c Philadelphia, Davis, 1979.
1979

Emergencies

- WA Burnette, William E.
292 **First Aid Guide.** Chicago, AMA, 1978.
.B 964f
1978

Food Hypersensitivity

- WD Breneman, James C., 1922-
310 **Basics of Food Allergy.** Springfield, IL, Thomas, 1978.
.B 837b
1978

Health Systems Agencies

- WA Montgomery County Health Systems Agency. Health Serv-

- 546 ices Planning Board.
.AM 3 **Proposed Health Systems Plan, 1978-83.** Rockville, MD,
.M 787p 1978.
1978

Histology

- QS Bevelander, Gerrit, 1905-
504.3 **Essentials of Histology.** 8th ed. St. Louis, Mosby, 1979.
.B 571e
1979

Insurance, Health

- History Numbers, Ronald
W **Almost Persuaded: American Physicians and Compul-**
225 **sory Health Insurance, 1912-20.** Baltimore, John Hop-
.N 971a kins Univ. Press, 1978.
1978

Mycology

- QW Bulmer, Glenn S.
180 **Medical Mycology.** Kalamazoo, MI, Upjohn Co., 1978
.B 938m
1978

Norethindrone

- QV **Norethindrone: the First Three Decades.** Edited by Mary
177 Jean Pramik. Palo Alto, CA, Syntex Laboratories, Inc.,
.N 834 1978.
1978

Parasitology

- WZ **Tropical Medicine and Parasitology: Classic Investiga-**
112.5 **tions.** Edited by B.H. Kean, Kenneth E. Mott, and Adair
.P 15 J. Russell. Ithaca, NY, Cornell Univ. Press, 1978
.T 856
1978

Peripheral Nerve Diseases

- WL Liveson, Jay Allan, 1937-
500 **Peripheral Neurology: Case Studies in Electrodiagnosis.**
.L 785p Philadelphia, Davis, 1979.
1979

Psychotropic Drugs

- QV **Mind-Influencing Drugs: Effective Management of Pa-**
77 **tients with Emotional Illness.** Edited by Martin
.M 663 Goldberg and Gerald Egelston. Littleton, MA, PSG Pub.
1978 Co., 1978.

Smoking

- ZHV Cancer Information Clearinghouse
5740 **Smoking and Health: an Annotated Bibliography of Pub-**
.C 215s **lic and Professional Education Materials.** Bethesda,
1978 MD, 1978.

Surgery, Oral

- WU **Textbook of Oral and Maxillofacial Surgery.** Edited by
600.3 Gustav O. Kruger. 5th ed. St. Louis, Mosby, 1979.
.T 354
1979

Surgical Instruments

- History Bennion, Elizabeth
WO **Antique Medical Instruments.** Berkeley, CA, Univ. of CA
162 Press, 1979.
.B 472a
1979

Wounds and Injuries

- WO Ayella, Robert J., 1925-
700 **Radiologic Management of the Massively Traumatized**
.A 976r **Patient.** Baltimore, Williams and Wilkins, 1978.
1978

Breast Neoplasms

- WP American College of Surgeons. Commission on Cancer.
870 **Short Term Patient Care Evaluation Study for Carcinoma**
.A 512s **of the Female Breast.** Chicago, ILL, 1978.
1978

Chronic Disease

- WT National Center for Health Services Research.
30 **A National Profile of Catastrophic Illness.** Hyattsville,
.N 277n MD, 1978.
1978

Cocaine

- QV Conference on Contemporary Issues in Stimulant Re-
113 search, Duke University, 1975.
.C 748c **Cocaine and Other Stimulants.** New York, Plenum Press,
1975 1977.

Drug Dependence

- QV Marks, John, 1924-
77.9 **The Benzodiazepines: Use, Overuse, Misuse, Abuse.** Lan-
.M 345b caster, Eng, 1978.
1978
WQ Ostrea, Enrique M.
240 **The Care of the Drug Dependent Pregnant Woman and**
.O 85c **Her Infant.** Lansing, Michigan, Dept. of Public Health,
1978 1978.

Facility Design and Construction

- WX Alford, Terry W.
140 **Facility Planning, Design, and Construction of Rural**
.A 389f **Health Centers.** Cambridge, MA, Ballinger Pub. Co.,
1979 1979.

Genealogy and Heraldry

- History **Marriages and Deaths from the Maryland Gazette, 1727-**
WZ **1839.**
22 Compiled by Robert Barnes. Baltimore, MD, Genealogical
.AM 3 Pub. Co., Inc., 1976.
.M 393
1976

Health Systems Agencies

- WA Central Maryland Health Systems Agency Inc.
540 **Draft Health Systems Plan.** Baltimore, MD, 1979.
.AM 3
.C 397d
1979

Heart Diseases

- WG Sokolow, Maurice
200 **Clinical Cardiology.** 2d ed. Los Altos, CA, Lange Med.
.S 683c Pub., 1979
1979

Libraries

- Z **Library Conservation; Preservation in Perspective.**
700 Edited by John P. Baker and Marguerite C. Soroka.
.L 697 Stroudsburg, Pa., Dowden, Hutchinson and Ross, Inc.,
1978 1978.

Occupational Diseases

- WA Daugaard, J.
400.3 **Symptoms and Signs in Occupational Disease: a Practical**
.D 236s **Guide.** Chicago, Year Book Medical Pub., 1978.
1978

Rural Health

- WA Wade, Torlen L.
390 **Planning and Managing Rural Health Centers.** Cam-
.W 116p bridge, MA., Ballinger, 1979.
1979

Thorax

- WF **Blades' Surgical Diseases of the Chest.** Edited by Donald
980 B. Effler. 4th ed. St. Louis, MO, Mosby, 1978.
.B 632
1978

Urologic Neoplasms

- WJ **Principles and Management of Urologic Cancer.** Edited by
160 Nasser Javadpour. Baltimore, MD, Williams and Wilkins,
.P 957 1979.
1979

Medical Miscellany

Horse Riders Urged to Wear Safety Helmets

Tired of jogging for your health? Get a horse. There are more than 10 million horses in the United States, and as many as 82 million Americans will ride a horse at least once during the year, says a recent AMA report.

Some of those riders will be thrown off. They will be stepped on or rolled on by their mount. They will get kicked by a flailing hoof, slashed by rope burns, bitten or lashed by low-hanging tree limbs.

John A. I. Grossman, MD, of the George Washington University Medical Center, in Washington, DC, and colleagues reports on a study of 110 injured equestrians brought to the emergency room of the University of Virginia Medical Center in Charlottesville from central and western Virginia and parts of West Virginia and Tennessee in a recent **JAMA** issue.

The riders were engaged in fox hunting, polo, steep-lechase racing, dressage and racehorse training. Most were amateurs.

There was little pattern as to age, sex or experience of the amateur riders and injury occurrence. Of the 110, there were 76 women and 34 men. Dr. Grossman points out that many more women than men are riders. Ages ranged from 1-64 years. Only 22 of the individuals were admitted to the hospital.

The most common injury was a bump on the head. Almost all of these could be avoided or lessened by wearing helmets, but fewer than 20% of the riders used protective headgear, he says. The second most common injury was a sharp blow to the stomach, with internal injuries. For those who were treated and sent home, broken arms and wrists were the most common injury. The arms are outstretched for protection during a fall.

In addition to wearing of helmets, Dr. Grossman recommends that tack—saddle, stirrups and bridle—be checked carefully and frequently. Some injuries are caused by failure of a strap of cinch.

JAMA Editor William R. Barclay, MD, in an accompanying editorial, pointed out that risk of injury is low for the expert horseman, and a person can participate in equestrian activities even at an advanced age.

"In counseling those who express an interest in equestrian activities, we should emphasize the positive aspects rather than the risks," Dr. Barclay noted.

"As a matter of personal observation, a day's ride on my hunter not only refreshes my spirits, but also seems to relieve the chronic backache that is aggravated by long hours of sitting at the editor's desk." □

Equestrian Injuries: Articles Available Through the Med-Chi Library

Equestrian Injuries: Results of a Prospective Study, by Grossman, J.A., **JAMA** 240(17): 1881-2, Oct. 20, 1978.

"The Mystique of the Horse is Strong Medicine, Riding as Therapeutic Recreation," by Mayberry, R.P., **Rehab. Lit.** 39(6-7): June/July, 1978.

"Biochemical Changes in Horses During a 50-Mile Endurance Ride." Lucke, J.N., **Vet. Rec.**, 102(16): 356-8, Apr. 22, 1978.

"Riding for the Disabled," Walker, G.M., **Physiotherapy** 64(10): 297, October, 1978.

"Letter: Brain Damage in Jockeys," d'Abreu, F., **Lancet** (7971): 1241, June 5, 1976.

"Incidence and Nature of Horse-Riding Injuries: A One-Year Prospective Study," Gierup, J., **Acta Chir. Scand.** 142(1): 57-61, 1976.

"Riding and Ataxia," Saywell, S., **Physiotherapy**, 61(11): 334-5, November, 1975.

"The Medical Hazards of Horse-Riding," Goulden, R.P., **Practitioner** 215(1286) 197-200, August, 1975.

"Therapeutic Horseback Riding for the Handicapped," Haskin M.R., **Arch. Phys. Med. Rehabil.**, 55(10) 473-4, Oct. 4, 1974.

"Horse-Play: Survey of Accidents with Horses," Barber H.M., **Br. Medical J.**, 3(879): 532-4, Sept. 8, 1973.

"The Sored Horse and the Horse Protection Act of 1970," Ongert, E.G., **J. of Am. Vet. Med. Assn.**, 163(9) 1097-9, Nov. 1, 1973.

"Riding Accidents," Danielsson, L., **Act. Orthop. Scand.**, 44(6): 597-603, 1973.

"Riding for the Disabled: A Role for the Veterinarian." **Vet Rec.** 91(16): 388-9, Oct. 14, 1972.

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JOURNAL EDITORIAL BOARD MEMBER DR. ELIZABETH B. SHERRILL as she appeared on the cover of the **Journal's** April, 1974 issue. (Photo by Dr. Sherrill's son, Bob Clement.)

HOW TO KILL AN ASSOCIATION

Don't participate beyond paying your dues—let "them" handle things.

Then complain that members have no voice in management.

Decline all offices and committee appointments—you're too busy.

Then offer vociferous advice on how they should do things.

If appointed to a committee, don't work—it's a courtesy appointment.

Then complain because the organization has stagnated.

If you do attend management meetings, don't initiate new ideas.

Then you can play "Devil's Advocate" to those submitted by others.

Don't rush to pay your dues—they're too high anyway.

Then complain about poor financial management.

Don't encourage others to become members—that's selling.

Then complain that membership is not growing.

Don't read the mail from headquarters—it's not important.

Then complain that you're not kept informed.

Don't volunteer your talents—that's ego fulfillment.

Then complain that you're never asked; never appreciated.

And, if by chance, the organization grows in spite of your contributions

Grasp every opportunity to tell the youngsters how tough it was; how hard you worked in the old days to bring the organization to its present level of success.

(Reprinted from the Journal of The Virginia Academy of Family Practice)



"Do you take traveler's checks?"

Medicine in Maryland, 1634–1900

Chapter 15

Editor: Douglas G. Carroll, Jr., MD (1915–1977)

Medical Reforms in Maryland (1848–76)

There were two important socio-medical developments between 1848–76. The first was the remarkable increase in the number of proprietary medical schools throughout the country with a tremendous increase in the number of MDs. The second was the development of various sects, one of the most enduring being the homeopathic physician movement.

In the late 18th and early 19th centuries, a major purpose of the medical societies was the elimination of empirics and quacks from practice. They tried to do this by founding medical schools and controlling licensure within the states. The original impulse for this movement came from the highly-trained European physicians in the Colonies. Elimination of competition and establishment of a monopoly does not seem to have been a major purpose early in the 19th Century. After 1830, however, with the increasing numbers of proprietary medical schools, more and more students of indifferent quality were accepted, and the quality of medical education deteriorated. There was a gradual loss of respect for the medical profession.

The second major movement in the 19th Century was the development of various sects, of which the homeopathic physicians were a major influence. A number of the sects arose from complex philosophical views as to the nature of disease. Homeopathic medicine arose in part as a reaction to the overuse of drugs. In the late 18th and early 19th Centuries, the majority of drugs used produced dramatic effects. Jalap and croton oil produced major diarrhea and dehydration. Phlebotomy was a dramatic operation which the patient could observe and feel. Mercury produced excessive salivation, but the drugs seemed to be used more because they produced an obvious and dramatic effect than for any observed benefit they may have had on the disease process. The use of drugs was based more on dogma than on observation of its effect on the specific patient.

The deterioration of the medical schools and the rise of medical sects were not entirely destructive forces. The increased number of doctors fulfilled the medical needs of a burgeoning population. It would be hard to prove that there was much difference in the effectiveness of the physician trained in the 18th Century from those trained in the middle of the 19th. Indeed, the gradual rejection of the heroics of Rush (cathartics, phlebotomy and mercury) was a step in the direction of allowing nature to heal.

Medical Education

The American Medical Association battled unsuccessfully for reform in medical education during the

first decades of its existence (1847–67). By 1870, the hopeful reformers of the pre-Civil War days were generally pessimistic about improving medical education. The Civil War itself had cut down on the number of proprietary schools and students, but this was merely a marking time for post-war expansion. By 1880, the catalogues of medical schools generally specified a high school diploma or its equivalent for matriculation. The “equivalent” often turned out to be whatever the applicant had, if he didn’t have a high school diploma.

In 1800, there were four medical schools in the US; in 1825, 18; 26 new medical schools were started between 1810–40; 47 between 1840–76; 114 between 1873–90. About 400 new schools were founded between 1800–1900.

Conflicting forces were at work. The proprietary schools continued to flourish, but new attitudes developed. The 1862 Morrill Act stimulated the land grant university and, in so doing, strengthened and brought into being the public high school. Although compulsory education existed in only seven states by 1896, the general quality and number of students was gradually improving at the high school level. The Johns Hopkins Medical School required a degree at its opening in 1893, but the Council on Medical Education of the AMA recommended only a year of college for medical school admission as late as 1906. By the time Flexner made his survey of a 155 schools in 1910, 16 required two years of college and six more were scheduled to require two years by 1910. In the same year, 50 other medical colleges required only a high school education or equivalent.

Prior to the Civil War, there was little laboratory medicine and even thereafter, the laboratory sciences were taught by practicing physicians. Between 1800–30, the school year was generally 13 weeks and made up almost entirely of lectures. By 1890, 76 schools required six months of courses. By 1910, practically all schools required four years of graded instruction.¹

Postgraduate training after the MD degree began about 1820 in Maryland at the Baltimore City Almshouse. There were both students, acting as clinical clerks, and physicians with the MD degree working with attending physicians. The students paid a fee, worked up new patients and made rounds with the attending physicians. The word “intern” referred to medical students during the 19th Century and did not receive its present meaning of the first year after medical school until around 1914. Two resident training programs started in Baltimore in the 1820s (Baltimore City Almshouse and University of Maryland Infirmary).

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In addition to these resident training programs, a tremendous number of American doctors visited Europe for training. One estimate is that 15,000 American doctors visited Germany and Austria between 1870-1914.

At the first AMA convention in 1847, a resolution recommending a single independent State Licensing Board in each state failed passage. There was little hope for reform in licensure until around 1875, when the chaos of a lack of any policy caused the writing of new laws concerning licensure and practice.

Hudson¹ states: "The new laws reflected a wholly new national attitude. No longer was the scene dominated by fear of class legislation, by the pervasive attitude of laissez-faire or Herbert Spencer's version of social Darwinism which made the patient responsible for his own folly when he chose his physician unwisely. The confused lawlessness of 1830-70 had by now convinced the populace and their lawmakers that some degree of State regulation was both proper and necessary." State Licensing Boards were a step in the direction of improving the quality of medical schools.

The early efforts of the AMA to improve medical education were doomed to defeat because the proprietors of the medical schools did not wish to improve or change the education system which was their livelihood. It was not until 1904 that the AMA formed a permanent Council on Medical Education staffed by outstanding men who inspected medical schools and rated them worthy or hopeless. Their reports were made public and resulted in the closure of 29 schools between 1906 and Flexner's report four years later.

The Flexner report documented many of the forces and activities which were already known so that his report came at a time when reform was already well underway and his efforts merely helped carry the stream faster.

The founding of the Johns Hopkins Medical School was based on German medical science and German education. The fact that it succeeded nearly two decades before the Flexner report shows that leading medical opinion was pointed in the direction of reform well before it was documented.

The major death-blow to private proprietary medical schools was the increasing requirement for laboratories, libraries and teaching space.

The Medical and Chirurgical Faculty from 1848-75

The major efforts of the Medical and Chirurgical Faculty in these years was to maintain itself as a viable organization, to maintain the Library and to educate practicing physicians. On all these counts, it failed. Between 1859-66, it held no meetings; the Library in 1856 was unable to purchase any books or to rebind those requiring it. A suggestion was made in that year to dispose of the Library to some other library within the city.

There were, however, evidences of the slow advance of medical science. In 1853, recent advances in auscultation of the lungs was reported by Dr. David Stewart. Dr. E. G. Edrington reported the ligation of both common carotids.

In this year there were 35 new members. The first

specialty society (the Pathological Society) was founded.

The Civil War interrupted the activities of the Faculty. It was not until 1870, under the leadership of Dr. J.R.W. Dunbar (he replaced Dr. Roberts, deceased, who had held office since the last formal meeting in 1859), that a new building on Courtland St. was purchased (1869). Thereafter, the Faculty met regularly up to the present.

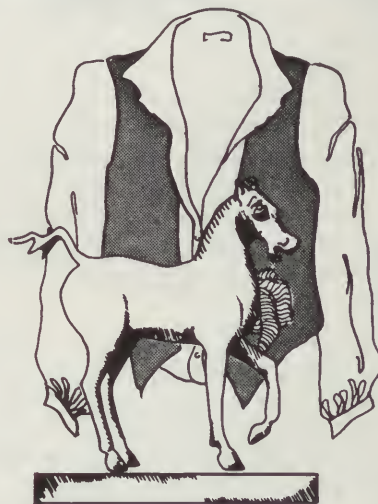
Thus the years 1849-76 reveal little advance in medical education or in the activity of the Medical Society, but new methods were being discovered. Chemistry was coming into its own as an important basic science. The microscope, histological stains, histology, pathology, the stethoscope, anaesthesia and surgery were making gradual, if unspectacular, advances, but, perhaps, the most important advance was the gradual realization that medicine could be a scientific profession, that the laboratory and hospital were the workshops of the physician and that the focal point of advance was in improved medical education. □

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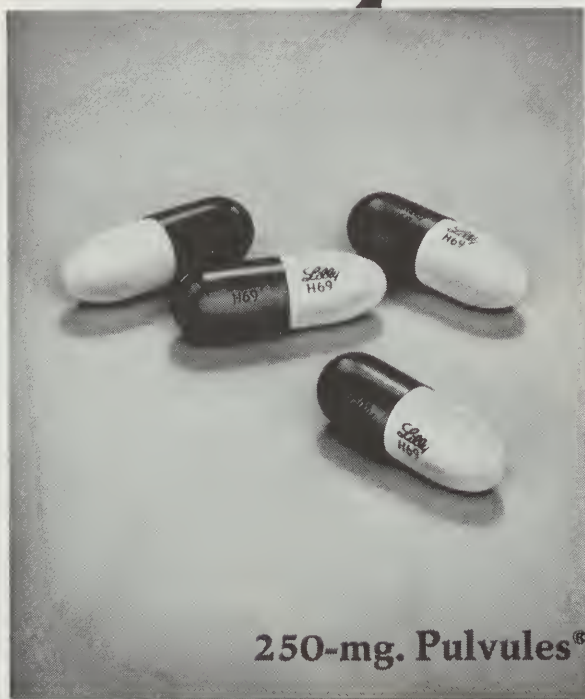
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Cover Story:

The Reverend Leslie R. Miles, Jr., MD: The Churchman as Physician, the Physician as Churchman— What It's Like to be **BOTH**

By BLAINE TAYLOR

Contact Mr. Taylor, **Journal** Managing Editor, for reprint and other data c/o the **Journal**, 1211 Cathedral St., Balto., MD 21201.

Prologue: Doctor, Priest, Sports Enthusiast

The tall, slender, graying, bespectacled physician rose to give the invocation at the 298th Meeting of the Med-Chi House of Delegates in Osler Hall in the Faculty Building at 1211 Cathedral St. in downtown Baltimore on Sept. 29, 1979. The doctor—Chairman of Med-Chi's Committee on Medicine and Religion (now in his fourth term)—was 53-year-old Reverend Leslie Roy Miles, Jr., MD, who is both a physician **and** an ordained Episcopal Priest, since 1972 Vicar-in-Charge of St. Peter's Episcopal Church at Lonaconing, a small Western Maryland town of 2,000 people with an additional 4,000 in its outlying areas. Dr. Miles has practiced family medicine there for 24 years, serving for 10 years prior to his ordination as a lay reader, senior warden and chaliceist (assisting priests in giving communion before becoming a priest himself.)

A Past President (and current Treasurer) of the Valley Ministerial Association, the Reverend Dr. Miles organized and supervises the Valley Church Volleyball League's seven teams. As Team Physician for all sports at the local Valley High School, Dr. Miles annually examines boys for football, soccer, wrestling, basketball, baseball and track, and girls for basketball, volleyball and cheerleading—at no cost to either school or students. In 13 years, he claims he's never missed a football game—at home or away—and attends most other sporting events as well.

A member of the Board of Directors of the Lonaconing Little League in baseball, Dr. Miles also organized and was first President of the "Football for Valley Club," led a drive in 1964 that raised \$7,500 to purchase football equipment for the then-infant Valley High team, and, two years later, helped raise \$13,000 to install lights on the football field, for which he, in addition, personally secured donations of labor and material for the job as well as physically labored on it, too!

Another drive raised \$5,000 for school band uniforms, while still another established a school health department (which Dr. Miles supervises) for the treatment and

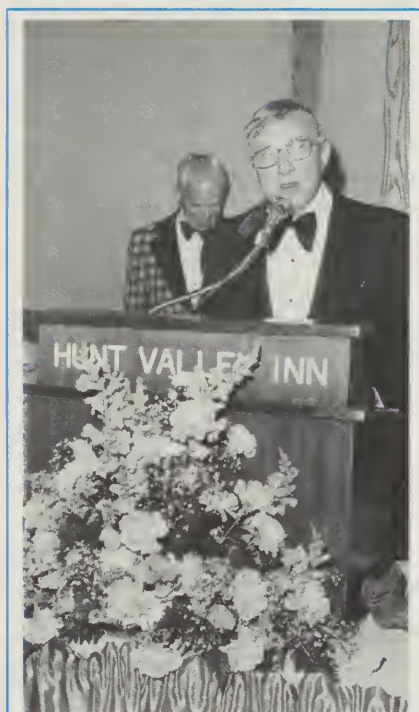
care of students. He is also physician to the three teams comprising the George's Creek Football League, plus being Treasurer of the Board of Directors of Boy Scouts of America Troop #26, and is its physician, too. In 1972, he was cited by the Lonaconing Recreation Commission for his "Outstanding work and contributions as a civic leader."

A long-time member of the town's Rotary Club, Dr. Miles has served as its President once and Secretary twice, and is a member, too, of both the local VFW and American Legion (during World War II, he served as a Medic with the US Third Army of the legendary Gen. George S. Patton, Jr. — whom he met and still considers "a great man"—and he saw combat in the Battle of the Bulge in Belgium, in Luxemburg and in the German Rhineland.)

Born in Huntington, WV in 1925, Dr. Miles obtained his BA degree at that state's University in 1949.

Medically, he received his MD in 1953 from the University of Maryland School of Medicine, and has been a member of the American Academy of Family Practice since 1958, receiving its Fellowship in 1972.

A member of the Allegany County Medical Society for 24 years (as well as of Med-Chi and the AMA), Dr. Miles was the Society's President in 1976, has twice served as its Secretary-Treasurer and has, for the past six years, been its Delegate to Med-Chi. This year, the Society elected him to the Med-Chi Council, while, in 1975, it recommended him for receipt of the prestigious A. H. Robbins Award for Community Service, which he won. (The honor is given once per state per year.)



DR. MILES SPEAKS at Med-Chi Annual Meeting on May 1, 1975 at Hunt Valley Inn, Cockeysville, MD, while Manning W. Alden, MD, listens at rear. (Photo by Jerry Goldberg, Guill Photo, Balto., MD.)

Dr. Miles is a member of the medical staffs of Sacred Heart and Memorial Hospitals (both in Cumberland) and Frostburg Community Hospital (where he has served two terms as Staff President); also, at Sacred Heart, Dr. Miles was the founder and first Chairman of the Hospital's Department of Family Practice, and is Medical Director of Lonaconing's 24-bed nursing home, too. In 1972, he was cited by the American Red Cross for "Outstanding cooperation with Red Cross blood programs."

Married to the former Donna Hutt, Dr. Miles has a son, Bruce, age 27, who is "herdsman" on a large North Carolina dairy farm; another, Donald, age 25, is head of the Respiratory Therapy Department at Haupshire Memorial Hospital in Romney, WV (his father, acting in his Ministerial role, married this son to a Registered Nurse) and a daughter, Diana, age 18, who graduated this year from Valley High School. The Miles have one grandchild, with another due in December, 1979.

All of his varied activities leave Dr. Miles very little time for hobbies, but he does enjoy reading Sherlock Holmes adventures, as well as historical books on the Second World War and the American Civil War (particularly those by the late author Bruce Catton), adding,

"I've very much enjoyed the **Journal's Health in History** series of articles. I think they're tremendous, just great!"

For 15 years, Dr. Miles has been a member of the American Academy of Sports Medicine, and it was with this aspect of his career that the interview began in the **Journal** office on June 21, 1979.

Sports Medicine

How long have you been involved with sports medicine, and what got you interested in it originally?

When I first went to Lonaconing, they didn't have anyone to examine the athletes, and just sent them to a doctor and told them they had to be examined. They asked me once if I would mind examining a soccer team, so I did. A few boys then came out for basketball, and I just sort of gravitated into it.

Do you have a lifelong interest in sports yourself?

I've always been an "athletic supporter"—but I haven't been much of an athlete myself. I've always been interested in sports, primarily football.

You look like you're in good physical shape yourself—trim, and not overweight...

I was; in 1976, I had a mild heart attack and, after that, I decided I'd better get in a little shape, because I was pretty flabby. I lost 25 pounds and weigh 160 now. I'm about 5' 10" in height. I **should** weigh between 150-155 pounds.

Cheerleader Ailments

In your examinations of various cheerleaders after their injuries, what kind of injuries did you find—ankles, feet, things like that?

Wrists, mainly, because they do cartwheels and pyramids and things of that nature. They get any kind of injury that an athlete gets.

Have you had any with broken arms or legs?

No. The worst I've ever had was a bad sprain of an ankle—ankle injuries probably more than anything else.

The Lure of Lonaconing

What brought you to Lonaconing?

I was hungry! I started my practice in Capon Bridge, WV, and it

was **really** a **rural** practice! When my family moved out—myself, my wife and two boys then—the population dropped to 99 in the community where we lived! A house call was 30-40 miles away, with home deliveries, etc. I was there about 18 months and netted about \$11,000-\$12,000. After Internship in 1953, **that** was a lot of money, as I made all of \$1,200 during the year I served my Internship, so I thought I was making a pretty fair living when I started to realize "This isn't it." There just weren't enough people in the area.

Initially, I heard about Lonaconing from a drug salesman who came by one day and told me that the people there were looking for a physician. He gave them my name and address, and the next day some people were down to see me! They said they'd pay my moving expenses, fix up some office space and give me an apartment rent-free until I felt I was able to pay. I decided that **anything** was better than what I had, and so came to Lonaconing at age 30. After a couple of months, I was able to pay the bills, and have done very well since.

Has the community grown a lot in the last 25 years?

No. There's very little transience. The town can only accommodate a small portion of the young people who grow up there because of the job situation, and the population has stayed basically the same. It's a suburban community in relation to Cumberland, MD. Many people work in local strip-mining. Geographically, it's very similar to the mountainous area of West Virginia that I left, although it's really suburban, not rural.

We have virtually every business represented in the town, but they're all small-scale.

Has your family enjoyed living there?

Yes. The young people have more than enough social activities to keep them busy! My boys could go a hundred yards from the house and camp out in a tent. They both did all the things rural people do.

Do you think you'll spend your retirement years there?

I probably will.

Prominence

Having almost been drafted, as



LESLIE R. MILES, JR., MD (Photo by Donna Miles.)

it were, into the community, you must be one of the area's most prominent citizens, right?

Well, it's like they say: Do you want to be a big frog in a little pond or a little frog in a big pond? This is what you amount to there. All these organizations—from the Rotary Club to civic improvement associations and so on—want me to be part of them. I don't mind it. I enjoy it. You **are** important to them, too. It doesn't make any difference if they're debating putting a park in or what—they want **my** opinion. The people think of you as a physician. You know everybody, and everybody knows you. On the street, it's "Hi, doc." It's a very friendly, congenial atmosphere. Now I'm treating the babies of people I delivered years ago, so you're very close to everyone. I practiced there for 23 years by myself and now I have an associate who is a boy I treated in grade school and high school, and treated his family all along and talked him into coming back after medical school because I needed the help. He's been with me a year and a half, and it's been a good feeling to have him with me.

Local Politics

Have you ever been approached by the townspeople to run for office?

Yes. I ran for Mayor once, in the mid-Sixties, but lost. There were two other candidates, and I came in third in a field of three. People would come into the office and say, "I think you'd make a good Mayor, but we'd rather have a doctor, and we think that's going to take too much of your time." That was the end of my political career!

Did you run as a Democrat or Republican?

They're **all** Republicans there! They have a standing joke that they're still looking for the two people who voted for Franklin Roosevelt! Fortunately, I happened to **be** a born and bred Republican, but they wouldn't have thrown me out if I was a Democrat, I don't think.

Some people **had** asked me to run for Mayor. What we tried to do was set up a slate with a Mayor and four Council candidates to run who were five businessmen, figuring

that we would have an interest in the community itself that the commuters who worked elsewhere wouldn't. We got four businessmen and myself, but, unfortunately, only one of the businessmen out of the five of us got elected. We tried to run as a party, but you just can't do that in an area like that—you run as an individual, as I found out. I didn't get elected mostly because I was a physician. I got 85 votes, while the winning candidate got a couple of hundred, out of a voting turnout of around 350 people.

Will you run again?

I don't rule it out.

So, one day I might be able to refer to you as "the Ross Pierpont of Lonaconing?"

(Laughingly) Right, right! Seriously, though, I might run again later on, as I get a little older. Now that I have an associate and some more free time, it's much more possible, but the two professions I already have—the clergy and medicine—keep me pretty busy.

The Clergyman

What decided you to become a Minister?

I've always been active in the Episcopal Church. Mine is a "mission" church as they call it. It's **not** self-supporting—and hasn't **ever** been. It's the oldest church in the community despite this, with 85 communicants at present who're actual members; 25 are in Sunday school who're **not** church members, plus about 10 others who come intermittently who're not members, either. It's very expensive to get a fulltime priest, and our church budget runs about \$12-\$14,000, while it takes about \$20,000 to get a fulltime priest—for salary, car allowance, utilities, etc. I'm salaried to the tune of \$170 a month, however.

So, again, you're doing this to fulfill a community need, as earlier you did as a physician?

Yes.

How did it all come about?

It took me a little over a year to become ordained. I studied with two priests once a month on Wednesday afternoons. They'd give me reading assignments in theology. The social, psychiatric and psychological parts of the seminary I'd already covered fairly-well in

pre-med and med school. At the end of this period, they said I was ready to be ordained. There's a special canon in the Episcopal Church that allows for ordination under these circumstances in an area of need.

Are you the only physician/priest in Maryland?

No. There're two other Episcopalians I'm aware of: George Merrill and Ira Fetterhof, a psychiatrist in Hagerstown, who was a priest before he was a physician. I am, so far as I know, the only person **practicing** both professions at once, however.

Roles in Conflict?

Being a scientist as a doctor, do you ever run into any conflicts between religious faith and scientific reasoning?

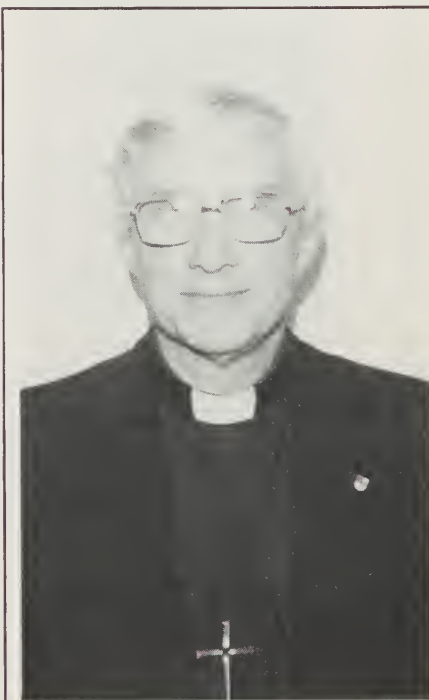
No, I don't have any conflicts.

Let's say you're treating a patient who dies while you're there. Do you administer the last rites?

Yes. I've jokingly said that my next step is to take up being a mortician!

That's really cradle-to-grave service! Any other problems connected with your life's duality?

The two complement each other really. They go together very, very nicely. I have patients come into the office whom I've seen for 20 years and they'll say, "I can tell



THE REVEREND LESLIE R. MILES, JR.
(Photo by Donna Miles.)

you this now that I know you're a Minister." I'll ask, "Why couldn't you tell me this before?" "Well," they'll respond, "I just feel better talking to you about this now." I do more marriage counselling in the office than in a church-sense. I get a lot more family problems, and it's easier to handle them working as both. Sure, you use tranquilizers for the nervous housewife, but I have the opportunity to also counsel her in a religious sense, which helps her get off the tranquilizers sooner and helps her solve her family problems sooner that I couldn't do before.

Do you perform abortions?

No. I can't do them.

If you were a surgeon and somebody came into your office for an abortion, what would you do? Is the Episcopal Church against it?

The Church is violently against it. I believe this: abortions are wrong morally and I don't think the State has any right to legalize or not legalize abortions. I don't think it's any of the State's business, but the Church's instead. It's up to the individual to decide.

Is this how you would counsel someone?

Yes. One of my parishioners is now married, but at the time, he and his wife were both in school when she became pregnant **before** they were married. They were thinking about an abortion. I told them it was their decision, that abortions **were** legal and that—if they did it—it should be done properly. I didn't advise them one way or the other. A week later, they called and said they'd decided to **have** the baby. I think the decision came from their religious training. I was **hoping** that enough had gotten through to them in Sunday school! They have a great little two-year-old now, with another on the way soon!

What about conflicting roles in giving birth control information as a physician to a 15 year-old unmarried girl? Do you feel, as a priest, you should tell her, "Hey! Don't do this?" As a physician, your saying "Here's how to do it," right?

If they're not members of my parish, I give them good medical advice only and have no qualms

about it. I'll often mention that "You ought to give this second thoughts. Why do you want the pill?" I try to get them at least to think about it—but the effort is usually a total failure. One member of my parish is a teenage girl on the pill. I've counselled her **both** ways—and she's taking the pill. In a sense, it's a failure on my part as her priest, but, still, as a physician, I think I have to give her what she wants. I'd rather give it to her medically than have her do something wrong. I've had Penecostal, born-again patients who accept me as a doctor also—but not as a priest.

From your duality, do you think you've gained a greater knowledge of each of the two roles?

I believe so. I think it's helped me, personally. I had a lot of qualms about entering the priesthood. During the times we'd be without a priest, when I was serving as a lay reader and chaliceist, I could conduct morning prayer, but couldn't celebrate the Mass. Before I was ordained, we were a year without a priest, when my bishop asked me to do it. My wife felt it was a big joke, so I ignored it. The bishop called me and came up to see me. I thought of all the ways this church could carry on without **me** being ordained and presented all these ways to the two bishops who came to see me. They pointed out that none of these could be worked out, and that the only other solution would be to close the church, so I eventually gave in. I have no regrets. It's been the greatest thing that ever happened to me! I enjoy it, and it's almost a hobby in the sense that there's just no way you can explain celebrating the Mass.

Is it more of a "high" than delivering a baby?

Oh, yes! I get a **tremendous** feeling out of it.

Have you ever heard a confession that complicated your role as a doctor to heal, as opposed to your priestly obligations to silence and confidentiality?

No, although I've come close. Initially, I counsel them as a priest and end up talking as a doctor. I'll see them in the church, with my collar on, then suggest they come to the office later! The two roles just work beautifully hand-in-hand.

Have you ever had to run out of church, jump in your car and go to the hospital?

Believe it or not, in seven years it's happened **twice**! One was a patient who was dying. On both occasions, another priest was there celebrating with me.

Which of the two roles has influenced the other the most? Has your being a doctor made you a better priest or the other way around?

The priesthood has made me a better doctor.

Has it given you more of a reverence for life?

Right. As a physician, in most cases, you're very scientific. Most physicians, I think, are religious, but you still look at disease and medicine as pathological things. You get a much better approach to life and death as a priest than you **ever** do as a physician. There's a sort of medical finality about death: "OK, it's all over. He's dead. I did everything I could do, everything that modern medical science prescribes, but we all know we're going to go." You turn your back and walk off to the next case. As a priest, you **don't** do this, because, in the clergy, you know that life **doesn't end** here, but that death is truly the **beginning**. This person who's died has, supposedly, gone to a **better** life. The body is a dead item, but there's a spiritual life, so you don't feel as lost as you do strictly as a physician. There's more for the priest, such as counselling of the bereaved family. It's given me a whole new philosophy of how to handle these people. I think it works out better. I'll retire as a physician before I do as a priest.

Thank you, Dr. Miles.

Acknowledgments

The author thanks Mrs. Mildred Chronister for secretarial services. This story marks the last such project commissioned by the late **Journal** Editor C. Thomas Flotte, MD, who died Dec. 15, 1976. □

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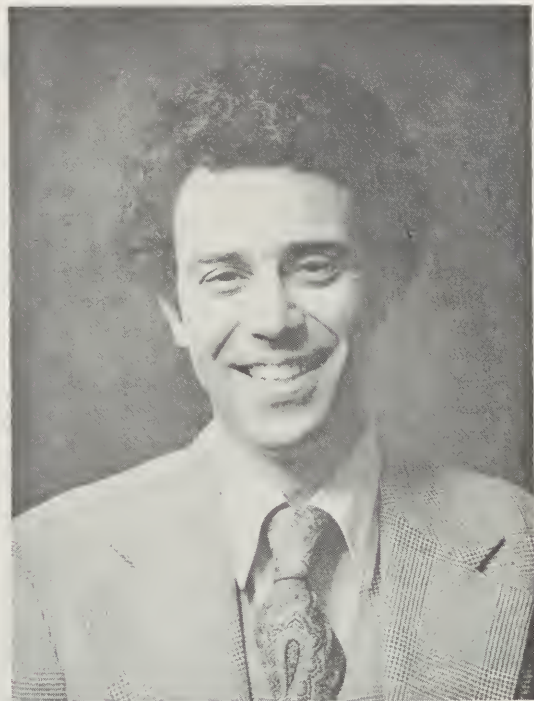
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Upper Gastrointestinal Bleeding

by John Chapman, MD

Dr. Chapman is affiliated with the University of Maryland School of Medicine, where he can be contacted for reprint and other data.

Presentation of a Case

The patient presented to the University of Maryland Hospital emergency room on Feb. 11, 1979 with a chief complaint of vomiting blood. This 47-year-old, white, male, alcoholic had previously been admitted to the Loch Raven Blvd. Veteran's Administration Hospital in Baltimore for myocardial infarction with electrocardiographic evidence of anteroseptal and inferolateral infarction.

Upon presentation to the emergency room, grossly melanotic stools were noted. The patient recalled a three-month history of hematemesis with concomitant change in the pattern of his bowel movements to "little bits" four-five times per day. He had a history of heavy alcohol use for 10 years and continued to drink two fifths of alcohol per day up to the day of admission in spite of severe vomiting.

During the three weeks preceeding admission, he noted increasing weakness with recurrent sternal pain which was described as crushing and radiating to the back, associated with shortness of breath and diaphoresis.

He gave a history of two pillow orthopnea and paroxysmal nocturnal dyspnea but denied ankle edema, increasing abdominal girth, jaundice, hepatitis or peptic ulcer disease. He has a 60-pack-a-year smoking history. His last admission to a hospital was three months prior to this admission. He received a one-year course of therapy with isonicotinic acid hxdrazide for conversion to a positive PPD skin test. His family history and past history were otherwise unremarkable. Upon admission, the temperature was 101°F, pulse 110, respirations 30 and blood pressure 140/90 supine which dropped to 120/80 with sitting. He appeared moderately obese and in no apparent distress, but was uncooperative and demanded medications for his nerves. His skin demonstrated spider angiomas. His sclera were non-icteric. Examination of the chest, heart and abdomen were normal. Rectal exam revealed guaiac positive stools.

Abnormal laboratory examinations upon admission were Prothrombin Time 13 sec./control 12 sec., partial thromboplastin time 27 sec., Hematocrit 31%, hemoglobin 10.5 gm/deciliter, and a BUN of 16 mg/deciliter. His hematocrit was 45% three months ago. His chest X-ray was normal without cardiomegaly. His EKG was without acute change.

Upon admission, a nasogastric tube was inserted and nasogastric lavage cleared the blood immediately. Six hours post-admission, the patient vomited bright red blood and a repeat hematocrit was 26%. Transfusion with packed red blood cells was begun. Upper endoscopy of the esophagus, stomach and duodenum was performed. A small bleeding point was seen in the distal esophagus and believed by the endoscopist to be as a Mallory-Weiss tear. The stomach and duodenum were

normal.

After 36 hours and 12 units of transfused blood, the patient's hematocrit stabilized at 30%. His hospital course was complicated by one episode of severe angina requiring transfer to the Coronary Care Unit. The patient was discharged on the 14th hospital day.

Discussion

GI bleeding is associated with a mortality of approximately 10%.¹ Management is now augmented by fiberoptic endoscopy, selective angiography, and barium contrast—air contrast radiography.

Pathophysiology and Clinical Manifestations

An understanding of the patient's response to the blood-loss, the rate and extent of the blood-loss and the capacity of the patient to further respond to volume depletion are necessary to make initial early treatment decisions. Is it an acute or chronic blood loss?

In an acute blood loss, the blood pressure may drop, the pulse may rise, a resting tachycardia may be present; the skin may show pallor and there may be a decrease in the urine output. In chronic blood loss, the changes are more subtle unless very severe.

One must be concerned with three organs that can be readily and permanently damaged, the brain, the eye and the heart, looking for signs and symptoms of cerebral ischemia, retinal artery spasm (which can occasionally lead to blindness) and cardiac ischemia.

Hematemesis suggests bleeding from above the ligament of Trietz, while melena suggests that the bleeding is above the ileocecal valve.

A blood pressure of 100 or less, or a pulse greater than 100 suggests greater than 20% blood loss. A 20 mm. fall in blood pressure upon sitting confirms a loss of this magnitude. A nasogastric aspiration must be made in all patients to assess the rapidity of blood-loss and its level and is useful as a part of the initial evaluation.

A rectal exam with a guaiac or Hemoccult test should be done and a blood sample should be obtained as early as possible for serum electrolyte values, BUN and hematocrit with sequential BUN and HCT determinations to check for cessation of blood-loss.

Early Therapy

The care of the GI bleeder should rest in the hands of a team composed of the primary physician, the gastroenterologist, the surgeon and, often, the radiologist. Resuscitation is the initial event, with intravenous saline and blood products. As this task is often carried out by others than the primary physician, a single, centralized flow chart is indicated upon which hourly observations of the patient's mental status, pulse (supine and upright), blood pressure, central venous pressure in the elderly or unstable, gastric aspirate, stool, urine output, Hematocrit, electrolytes and therapy (blood products, intravenous fluids, and drugs) are recorded. After resuscitation, then, one's efforts are turned to diagnosis.

Diagnostic Methods

There are six major diagnostic methods.

First: the history. Pain suggests a GI lesion penetrating the muscle layer while gastritis Mallory-Weiss and bleeding varices are usually painless. Vomiting preceding the bleeding suggests Mallory-Weiss. Previous episodes of bleeding can suggest recurrence, weight-loss suggests malignant disease. Drug and alcohol use is important to assess their effect on the patient's status. A history of cancer or aspirin use carries with it an increased risk of bleeding from gastritis.

Second: the physical exam. In the exam of the skin, one looks for the stigmata of alcoholism, Osler-Weber-Rendu or skin manifestations of Inflammatory Bowel disease. In examination of the lungs, one wants to rule out aspiration if possible. A thorough neurological exam is necessary to look for intracranial disease which might have resulted in a Cushing's ulcer.

Third: is the laboratory, to determine the impact on the patient. Serum-blood chemistries should include Hematocrit, electrolytes, coagulation factors and BUN. An EKG, arterial blood gases and a routine chest check are also indicated in patients 30 or older.

The final three diagnostic tools are endoscopy, selective angiography and barium contrast radiography.

Endoscopy

The development of the fiberoptic endoscope in 1958 significantly enhanced the role of endoscopy. In the absence of severe pyloroantral deformity, the duodenal bulb and the proximal duodenum can be examined in 95% of patients.² There are relatively-few contraindications to fiberoptic endoscopy, and the procedure can be accomplished on an emergency basis with the patient in the hospital bed. The overall mortality rate of endoscopy is 0.019%.³ Peptic ulceration, cancer, varices, esophagitis, gastritis and the Mallory-Weiss syndrome can be well-visualized with endoscopy and biopsies of masses can be obtained.

According to Iglesias, et al, prompt endoscopic diagnosis of upper GI hemorrhage has value of specific diagnosis and management.⁴ In his study done at Cook County Hospital with 789 patients admitted as Upper GI bleeders, 45% had more than one lesion. Erosive hemorrhagic gastritis was the most common lesion, followed by gastric ulcer, esophagitis and duodenal ulcer. The importance of early endoscopy was emphasized by a decrease in detection rate of lesions with an increase in time interval between the onset of bleeding and the time of endoscopy. Iglesias argued that finding the bleeding source is important to direct the management and treatment. For example, a precise diagnosis of gastric ulcer which has continued to bleed past 12-24 hours of medical management should be treated surgically, while erosive gastritis is treated medically, even after prolonged bleeding.

Eastwood in 1977 reviewed the results of four prospective controlled trials comparing early endoscopic approach to less aggressive methods.⁵ That endoscopy is the more accurate diagnostic tool is not questioned; however, the anticipated benefits of early diagnosis, such as more effective treatment, reduced transfusion

requirement, more rational use of surgery, decreased length of hospitalization and improved survival, have not resulted. He states that the necessity for a definite diagnosis has not been proven, that endoscopy must assume that the potential benefit outweighs the risk and that endoscopy is expensive. He concluded by suggesting that restraint be exercised until clinical trials can be evaluated.

Oddson, citing E. D. Palmer that it **has** been established that the mortality rate resulting from upper gastrointestinal hemorrhage increased if patients are treated medically without diagnosis of the specific site of bleeding.⁶

Obviously, the individual physician must use his or her own judgment as to how and when endoscopy is indicated in the diagnosis and management of the UGI bleeder.

Selective Angiography

Shenow suggests "If you don't get along with your surgeon, make friends with your radiologist."⁷

Angiography is generally reserved for the patient with a negative or non-diagnostic endoscopic evaluation. Massive bleeding prevents the endoscopist from getting a good look. Here, the contrast media may extravasate into the alimentary canal and delineate the source of bleeding. To be effective it must be done while bleeding of at least 1/2 ml./min. occurs and **before Barium** is given. Some bleeding can be demonstrated by angiography where it is often missed in endoscopy, particularly in the colon. Patients who are poor surgical risks because of pulmonary or cardiovascular disease, are candidates for arterial embolization.

Angiography is the method of choice for diagnosis of A-V malformation of the small bowel and can also demonstrate tumor vascular blush and aneurysm. A new and increasing problem in the elderly is bleeding angiodysplasia of the right colon.

Barium Contrast Radiography

This subject is very appropriately reviewed by Oddson et al.⁶

For at least 50 years, the barium exam was the primary diagnostic procedure. Now it is secondary to endoscopy and angiography. Limitations are that mucosal detail is difficult to evaluate in the presence of blood and clots in the stomach. Superficial lesions are virtually impossible to identify. Even though the lesion may be identified, it may not be the bleeding site. Finally, the barium in the GI tract interferes with any subsequent angiographical study or treatment.

Barium examination of the upper GI bleeder is useful if endoscopy is contraindicated or unsuccessful, and the active bleeding has been terminated. It is also useful if it is the only method available.

Summary

Upper GI bleeding is one of the more common problems encountered by physicians taking care of adult patients. This problem requires prompt evaluation of the extent and site of the bleeding, with an appropriate understanding of the pathophysiology, the differential diagnosis, the diagnostic tools available, the

specific therapy for the specific underlying cause and, finally, the ability to effectively make decisions as to the course of management of the individual patient.

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Aspirin: Its Multiplicity of Side-Effects

By JOHN C. KRANTZ, JR., PhD

Dr. Krantz is Professor Emeritus of the Department of Pharmacology at the University of Maryland School of Medicine. For reprint and other data contact him at Gibson Island, MD 21056.

There is **no** drug available that cannot be improved upon. The action of most drugs is accompanied by side-effects. These may be intolerable and render the therapy unbearable or may be of such minor character that the patient is unaware of their occurrence. Indeed, certain drugs elicit side-effects that can be as useful in therapy as their principal action. A classical example is that of the antihistamines that have been found useful in the treatment of insomnia. The principal use of aspirin depends upon its value as an analgesic and anti-inflammatory agent. In this use, minor gastric intolerance is sometimes encountered that is obviated by well-buffering the drug and the ingestion of much water with the tablet.

When the dosage of aspirin is increased, other interesting side-effects appear, such as the reduction of blood-cholesterol levels¹ and the lowering of blood-sugar levels.² Each of these side-effects may be beneficial to selective groups of patients.

Another side-effect of aspirin is production of micro-bleeding of the gastric mucosa. The patient is unaware of this effect and it can be avoided by well-buffering the aspirin and taking the dose with much water.

Another most striking side-effect of aspirin is upon blood platelets. The drug diminishes the aggregation of platelets, which is a step in the initiation of the clotting process. Weiss³ in 1967 observed that the ingestion of small doses of aspirin caused a minor increase in the bleeding time of normal subjects. This was due to the effect of aspirin upon the aggregation of platelets. This observation suggested the possibility of the use of this side-effect of aspirin in the prevention of diseases owing to the clotting of the blood in the brain, heart or other organs. Other drugs, such as phenylbutazone and indomethacin, also evoke the inhibiting action on platelet aggregation, but aspirin offers the optimal use for mass medication, presenting the greatest ratio of benefit/risk.

It is of interest that this is not the action of salicylic acid as sodium salicylate does not produce the effect. It appears that the acetyl group in aspirin is the functioning factor. It acetylates the platelet and prevents the aggregation process. Indeed, the acetylation endures throughout the life of the platelet, four-seven days.

Our knowledge of the mechanism of the action of aspirin in the prevention of platelet aggregation is in a state of flux. It is generally agreed that it is concerned with its effect upon the prostaglandins which enjoy a multiplicity of roles in many tissue functions. PGX, one of the most recently isolated prostaglandins, plays a key role in the prevention of platelet aggregation. It is postulated that platelets impinging upon the inner lining of blood vessels release prostaglandin endoperoxides PGE₂. These cause platelet aggregation. Simultaneously, the cell wall releases an enzyme which converts

the endoperoxides to PGX, thus preventing platelet clumping.

Aspirin, indomethacin and other anti-inflammatory drugs appear to block the conversion of arachidonic acid to PGE₂, that causes platelet aggregation. This allows PGX to function uninhibited in its capacity to prevent platelet aggregation.⁴ It is clear that our understanding of this intricate mechanism is still in its infancy and much work will be required before our knowledge of it is complete.

Of special interest is the ability of the aggregation to be initiated by alternative pathways so that hemostasis is not impaired in the normal person.

Reports are available from many clinical centers indicating the value of aspirin in the prevention of vascular accidents. For example, in 1974, British investigators⁵ reported that 600 heart attack patients who had taken one aspirin daily had 25% fewer heart attacks than those who had taken a placebo. The evidence at hand bespeaks the benefit/risk ratio for mass medication is high. It would appear that individuals who have suffered a heart attack or "little stroke" might reduce their chance of a second episode by the ingestion of aspirin daily.

Whether or not it would be prudent for all persons in middle-life and after to daily ingest aspirin to guard against a vascular accident is problematic at present. One must wait until many more results are available from the present ongoing studies.

If Felix Hoffman, who introduced aspirin into medicine at the turn of the Century, were alive and viewed the expanding spectrum of the action of the drug, he would be greatly gratified. The author is reminded of the words of Emerson, writing of the hand that rounded St. Peter's dome, "The conscious stone to beauty grew; He builded better than he knew."

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Upper GI Perforation by Metallic Wire Presenting as Acute Cholecystitis

By ASHWIN I. MEHTA, MD, FACS and PAUL G. HEROLD, MD

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Abstract

A patient with wiry metallic foreign body perforating from the pylorus into the liver bed is presented. He came with the picture of cholecystitis. The patient was unaware of swallowing the wire. The situation was confirmed by exploration and removal of wire perforating from the pylorus going into the liver bed.

Case Report

This 60-year-old white male, KT, was admitted to Church Hospital on Dec. 26, 1977 with pain in the epigastrium and right upper quadrant of three weeks duration. It was associated with some nausea, but no vomiting. He had some tenderness in the right upper quadrant. No rebound tenderness. Bowel sounds were normal. The temperature was 37°C (99°F) pulse 82/minute, regular, blood pressure 138/78 mm. of mercury. Hemoglobin was 11.6 gms./dl. WBC was 8,000/c.m.m. The differential showed a shift to the left. Serum amylase was 58 units per dl. BUN, blood sugar and electrolytes were within normal limits. Chest X-ray was unremarkable. Gallbladder series was normal. Upper GI series was normal except for a wiry metallic foreign

body in the right upper quadrant. Multiple lateral and oblique views showed the wire to be anterior to the pylorus. (Figures 1 and 2) The patient on close questioning denied swallowing any such foreign body. He was prepared by giving one day pre-op antibiotics: Cephalothin 2 grams every six hours IV and Gentamycin 80 mg. every eight hours intramuscularly.

At operation, there was marked edema in the subcutaneous, extrafascial and preperitoneal tissues. After entering the abdomen, the omentum was found to be adherent to the liver in the form of a mass. It was freed-up, which revealed an abscess cavity with white pus. Gram stain revealed occasional polymorphonuclear leukocyte, rare red blood cells and debris, but no bacteria. Culture showed micrococci species—probably skin contaminant. The pylorus was freed-up from the liver. A metallic wiry foreign body was seen tented between the pylorus and the liver going from the pylorus into the liver bed. It was taken out. He did well post-operatively and was discharged on Jan. 4, 1978. Pathology Report: Metallic wire-like structure from omentum gross diagnosis only.

Comment

Accidental swallowing of metallic foreign body such



FIGURE 1 GI Series Frontal Projection showing wire in relation to stomach and duodenum.



FIGURE 2 GI series Lateral View showing wire in relation to stomach and duodenum.

as a pin, safety pin, knitting needle or sewing needle is a common event and usually the patient is aware of such an accident. One of us (Dr. Herold) had a similar case some 15 years ago when a lady presented with a similar

picture of cholecystitis. She was explored and was found to have a sewing needle with thread perforating from the pylorus going into the gallbladder. It was taken out and the gallbladder area was drained. She did well. □

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Experience of One Year of Cancer Screening

By JOSEPH M. MILLER, MD and CAROLYN SPEIGHT, LPN

Both authors are affiliated with Provident Hospital, Inc., of Baltimore, MD 21215, where they can be contacted for reprint and other data. This work was fundamentally supported by a grant from the Morris Goldseker Foundation of Maryland, Inc.

The initial thrust of the program was to identify women in an at-risk population who might exhibit cervical and vaginal cytologic changes which might foretell a premalignant or a malignant state. A rising incidence of cancer in the black female was an immediate cause of concern.

Although this project was initiated to supply a special need, its incorporation into the general basic services supplied by an outpatient department is strongly recommended. Usually, these divisions include emergency care, walk-in clinics, general clinics, specialty clinics and home-care programs. The practice of preventive medicine, which seeks to maintain the normal healthy state or to discover early disease to prevent serious complications, is a growing facet of any health maintenance organization.

Medical screening of such nature under proper environmental conditions is appropriate on-going care necessary for the well and the sick. These programs should not be expensive. Laboratory studies should be minimal and inexpensive. The plan should be well-constructed and it should include education, informed consent, proper environment, good outpatient services to which patients may not only be referred for treatment, but **from which** patients may be referred, and good feedback relationships to patient and doctor to obtain a maximal therapeutic result.

The prime objective of the screening program is the indoctrination of the screenee without a regular source of medical supervision with the concept of having an annual examination and to encourage the use of auxiliary health services in a preventive care program. About 60% of cancer which affects the general population will be in the skin, lips, breast, cervix and rectum.

These areas are easy to examine and the entire examination can be done with the usual office equipment. The reward lies in the discovery of an unsuspected early lesion, which usually is readily curable. Objection to running screening programs is chiefly mounted in expense, and the assertion that other functioning clinics can do the same work with little increase in expense.

For those physicians who might wish to conduct such a program, the cost, *modus operandi*, results and suggestions emanating from the study are reported. The general target population was the group living in the perihospital geographical environment. The total population (1970) in 39 census tracts was 211,026, of whom about 204,734 (97%) were black. Although all applicants were examined, the ones particularly sought were those in the high-risk group, which include women who;

- 1—Had never had an examination of this type before.
- 2—Began sexual activity at an early age.
- 3—Were past the child-bearing age.
- 4—Were in a low economic class.
- 5—Were medically indigent.

Cost is a problem faced by any hospital administrator contemplating a new program. A screening plan of the type to be described can be effected for about \$15,000 per year to do 1,000 examinations. This sum includes the wages of a Licensed Practical Nurse to do the cervical smears and to care for the involved clerical work; \$4.84 to have each slide examined and \$1,000 for gowns, specula, slides, applicators, fixative and dipsticks for urinalysis. The cost of each examination is about \$15. The sum is large, but when the expected cost of hospitalization and therapy for one advanced lesion is contemplated, the price of the examination pales in comparison.

Most of the cervical smear slides were interpreted by cytologists working in the Baltimore City Health Department using guidelines established by the National Cancer Institute. The rest were examined in the Pathology Department of this Hospital.

After registration, the candidates were asked if they had had abnormal bleeding of any type, had noted unexplained lumps or had unhealed sores. The physical examination directed attention to the blood pressure, skin, mouth, neck, thyroid, breast, genital tract (pelvic examination) and rectum (rectal examination). A urinalysis for glucose and protein was also done. The cervix was inspected through a vaginal speculum for color, discharge and ulceration. A cervical and vaginal smear was then made in the following manner.

- 1—A cotton-tipped applicator moistened with a solution of physiologic saline was inserted and twisted in the cervical canal, and the cervical mucus was transferred to the slide.
- 2—The curved end of a wooden cervical spatula was abutted in the cervical os and turned to obtain epithelium. If the os was stenotic or obliterated from age or previous surgical procedure, the applicator could not be inserted. An appropriate notation was then made on the laboratory request slip.
- 3—The spatula was then immersed in the lateral vaginal pool and the combined specimen was placed on the slide.
- 4—The slide was sprayed with fixative.

Screenees were also given printed material dealing with self-examination of the breast, which was supplied by the American Cancer Society. The importance of looking for the early signs of cancer was stressed during the examination period.

The free program was advertised by notices on television and radio, and in the newspaper. A distinct effort was made to contact community leaders who could spread the word in their own sphere of influence. Advertising placards were placed in strategic areas in the Hospital, and all screenees were given a card detailing the service to pass to a friend. Perhaps the greatest source of referral was by word-of-mouth from a screenee to a prospective subject.

A compliance—appearance rate of 74% was obtained for the Fiscal Year of June, 1977—May, 1978. Appointments were made by the screenee on a time basis within two three-hour clinic periods. In all possible instances, the individual was advised by telephone on the preceding day of the approaching appointment. Still because of weather, forgetfulness or continued inattention to health matters, one of every four individuals did not appear for examination.

Results

In the period of survey, 972 women were seen. Racial composition was black (88.8%); white (10.5%) and other (.7%). These figures approximately parallel the composition of the population about the Hospital.

Abnormal slide readings were reported in 47 women (4.8%). Of these 47 interpretations, 17 (1.7%) were suspicious, 2 (.2%) were positive and 28 (2.9%) were inconclusive. When the various suggested diagnoses were more completely investigated, only two positive results remained.

Trichomonas vaginalis was found on the cervical smear in 206 instances (21.2%). In two large reported series, De Carvieri¹ found an 18.2% (315/1,732) incidence and Naguib² unearthed one of 14.5% (623/4,290).

Bard³ states that 30-40% of abnormal smears are associated with the presence of *Trichomonas vaginalis*. In this study, in only 10 (1%) of the individuals was the morphology of the slide disturbed enough by the inflammatory exudate to make interpretation difficult. Of the 47 slides classed as abnormal, 9 (19.1%) contained *Trichomonas vaginalis*.

The incidence of estrogen-like activity in the vaginal smear is of more than passing interest. Considerable variation is seen in the age of the menopause, but in the majority of instances, the menses cease between the ages of 45-50. Of the 972 women in the study, 441 (45.3%) were over the age 45. In this large subset, 63 (6.4%) showed estrogen-like activity. When the group was further narrowed, 51 (5.2%) were found to be five years past the menopause and still showed activity. Five women in this particular group were also infected with *Trichomonas vaginalis*. Only six women over 45 carried the protozoan and this 6% contrasts rather sharply with the overall incidence of 21.2%. The great difference may be related to a decreased sexual exposure after 45, or the beneficent effect of estrogen on a certain group of older women. Bard emphasizes the observation that a falsely high level of estrogen activity may be associated with *Trichomonas* infection which makes the estimation of estrogenic activity of doubtful value when the protozoan is present.

After the administration of estrogens for therapeutic purposes is eliminated, difficulty may be encountered

in explaining the presence of estrogen-like activity. Reasons for this observation include granulosa and theca cell tumors of the ovary, the administration of digitalis, related cardiac glycosides and cortisone and *Trichomonas vaginalis* infection. A certain amount of estrogen must also be made by atrophic ovaries after the menopause, and some estrogen is always manufactured by the adrenals. Although continued activity in repeated smears in the post-menopausal woman must arouse suspicion, a ready answer for the observation may not always be found.

Unsatisfactory smear results can be ascribed to:

- 1—Poor technique in making the smear.
- 2—Vaginitis of any type producing an inflammatory exudate hindering cytologic analysis.
- 3—Smears made just at the onset or termination of menstruation which were too bloody to interpret.
- 4—Too scanty or too thick a smear.
- 5—Vaginal douching within 12 hours of the examination.
- 6—Inability to enter a rigid cervix with the applicator.
- 7—Lack of columnar cells or too scanty an endocervical component. Columnar cells serve as a marker for the cytologist and indicate, if present, sampling of cells above the squamo-columnar junction.

Disposition of patients with an unsatisfactory reading due to a lack of columnar cells followed a directed course.

1—If the smear was from a woman at any age through five years after the menopause, the subject was recalled in eight weeks, and another slide was prepared. A second slide, still lacking columnar cells, would permit classification as "negative."

2—A slide without columnar cells in a patient who was five years past the menopause was classified "negative." The exception to this category was the patient who also showed estrogenic activity, and then, the smear was considered to be unsatisfactory. A second similar unsatisfactory test was a reason for colposcopy.

All patients were notified by mail of the results of the examination, and those with positive, suspicious, inconclusive or unsatisfactory results were requested to return for further evaluation. A diagnosis was given to everyone in the program.

The by-products of the survey are numerous. A large number of individuals with hypertension, which is rampant in the black population, have been uncovered and referred for treatment. A small number of people with diabetes mellitus have also been unearthed. A carcinoma of the breast was discovered and sent for therapy; 78 men of all ages have also sought screening. One individual was found to have a carcinoma of the prostate and one man had a basal cell carcinoma of the face.

In all, five carcinomas have been found in 1,050 patients. If the program had not been in existence, treatment in all of these individuals would have been delayed.

Summary

A cancer screening clinic built initially around the discovery of cervical dysplasia and cancer has served well as an excellent general screening clinic. The indoctrination of the screenee with the concept that an annual examination is good prophylactic medicine is the hope for the program. A number of other diseases unrelated to cancer have been uncovered by the investigation.

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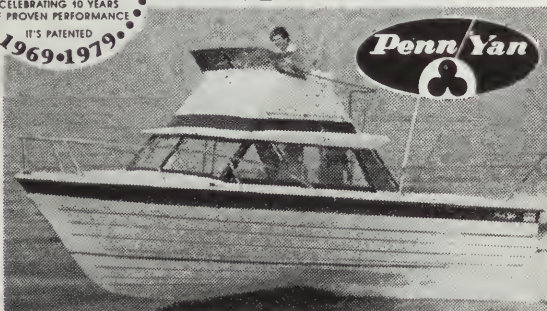


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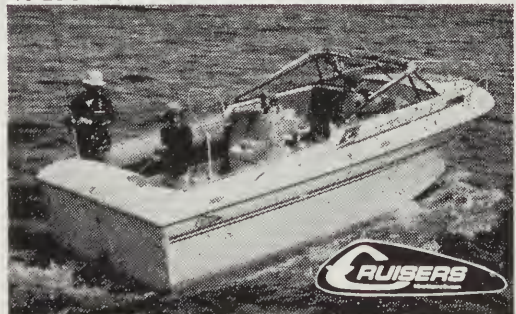


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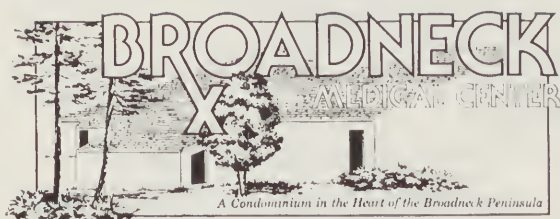
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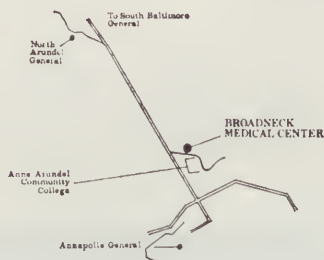
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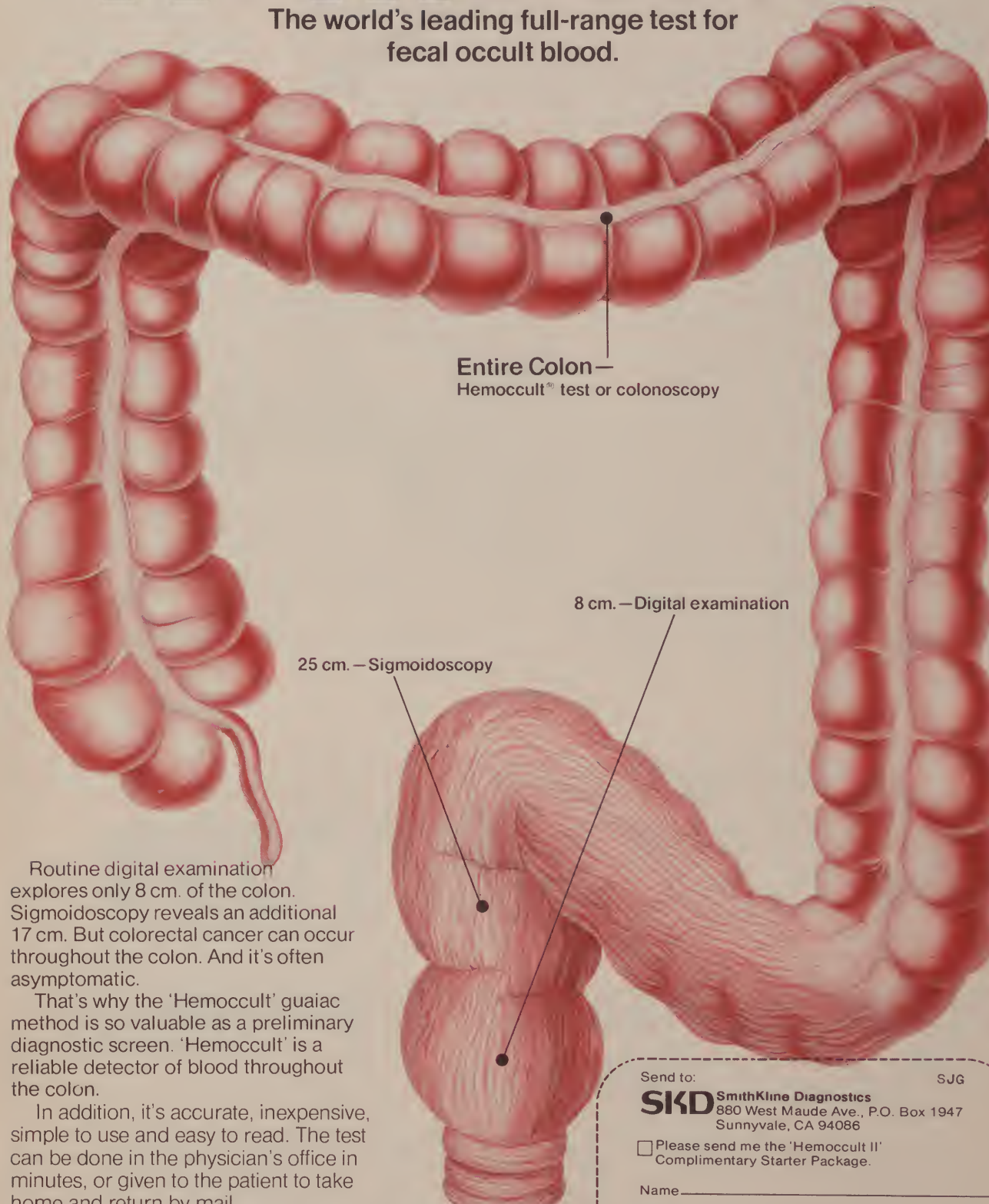
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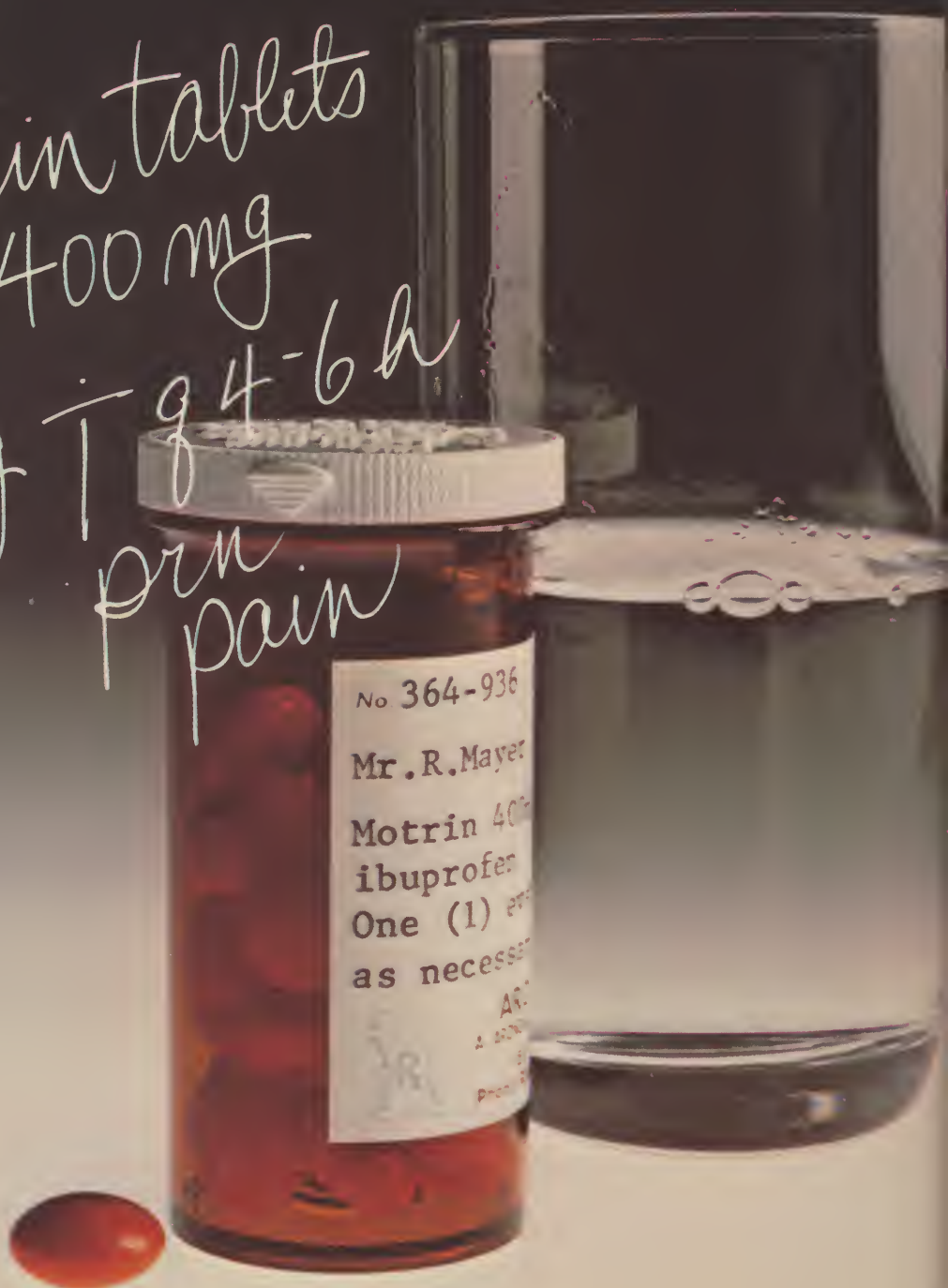
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Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL as cases become final.

IN THE MATTER OF EDWARD E. HOLT, MD, BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention and pursuant to Article 43, Section 130 of the Annotated Code of Maryland, the Peer Review Committee of the Medical and Chirurgical Faculty of Maryland initiated an investigation into the medical practice of the Respondent, Edward E. Holt, MD. Thereafter, the Commission on Medical Discipline of Maryland determined to charge Edward E. Holt, MD with certain violations of the Code. The violations charged involve the following subsection of Article 43, Section 130(h):

Professional and mental incompetence.

Appropriate notice of the charges and the grounds from which they arose was given to the Respondent, and a hearing on said charges was held before the Commission on Dec. 19, 1978, before John E. Adams, MD, Chairman; Jerome J. Collier, MD; John Ball, MD; Karl F. Mech, MD; Francis Mayle, Jr., MD; Frank Shipley, MD; Arthur Keefe, MD, and Vincent J. Fiocco, MD, constituting a quorum of the Commission. The Respondent appeared, represented by Charles P. Howard, Jr., Esquire. Stephen J. Sfekas Assistant Attorney General, presented the case on behalf of the Commission. Jack C. Tranter, Assistant Attorney General, advised the Commission on Rules of evidence.

At the time of the hearing, Mr. Sfekas presented Kennard Yaffee, MD, a member of the Peer Review Committee of the Baltimore City Medical Society, as a witness. A report of the Family Practice Unit of the University of Maryland Medical School was also presented.

The Dec. 19, 1978 meeting was continued to Jan. 2, 1979. At that time, the Respondent, after consulting with counsel, agreed to plead guilty and to enter into a Consent Order as proposed by the Commission.

Findings of Fact

The Commission finds

1. That the Respondent lacks sufficient knowledge and ability to engage in the independent practice of medicine.
2. That the Respondent has a significant degree of organic brain disease which contributes to his inability to engage in the independent practice of medicine.

The Commission, therefore, concludes as a matter of law that the Respondent is guilty of the charges of professional and mental incompetence.

Order

UPON the foregoing Findings of Fact and Conclusions of Law, it is this 2nd day of January, 1979, by the unanimous vote of the members of the Commission on Medical Discipline hearing this case

ORDERED that the license to practice medicine and surgery in the State of Maryland heretofore issued to the Respondent, Edward E. Holt, MD, by the Board of Medical Examiners, is hereby REVOKED; and, be it further

ORDERED that the aforesaid revocation shall not be effective until March 4, 1979 in order to permit the Respondent to make alternate arrangements for his patient's care, and be it further

ORDERED that after March 4, 1979 if the Respondent enters into a totally supervised medical practice acceptable to the Commission, the Commission shall stay the revocation of his license and place him on probation subject to the following conditions:

1. That Respondent practice only in a totally supervised setting approved by the Commission.
2. That Respondent's supervisor or preceptor submit quarterly reports to the Commission.

3. That Respondent continue in treatment with Addison W. Pope, MD or some other physician acceptable to the Commission.

4. That the physician treating Respondent submit quarterly reports to the Commission, and be it further

ORDERED that in the event the Respondent's revocation is stayed and he is placed on probation, violation of any of the foregoing conditions of probation, submission of a report by his supervisor or preceptor indicating that he is not practicing medicine competently or submission of a report by his personal (treating) physician indicating that he is not physically or mentally capable of practicing medicine competently may result in the withdrawal of the stay of the revocation of his medical license. Such action may only be taken following notification to the Respondent and a hearing before the Commission and be it further

ORDERED that if Respondent's revocation is stayed and he is placed on probation, two years from the date of this Order the Commission will entertain a petition to reinstate the Respondent's medical license without any condition or restriction whatsoever or alternatively to modify any of the foregoing conditions, and be it further

ORDERED that a copy of this Order be filed with the Board of Medical Examiners of Maryland in accordance with the Maryland Code, Article 43, Section 130(m).

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

Consent

By this Consent, I hereby accept and submit to the foregoing Order and its conditions. I acknowledge the validity of the Order as if made after a hearing at which I would have had the right to counsel, to confront witnesses, to give testimony and to call witnesses in my own behalf, and to all other substantive and procedural protections provided by law. I also recognize that I am waiving my rights to appeal any adverse ruling of the Commission that might have followed any such hearing. I further recognize that in the event I am able to effect a stay of the revocation of my medical license, failure to abide by the conditions of the resulting probation may result in the withdrawal of the stay and the reimposition of the revocation of my medical license.

I sign this Consent without reservation, fully understanding its meaning and after consultation with my counsel.

EDWARD E. HOLT, MD

STATE OF MARYLAND, CITY/COUNTY OF Baltimore to wit:

I HEREBY CERTIFY, that on this _____ day of _____, 1979, before me, the subscriber, personally appeared EDWARD E. HOLT, MD, and he made oath in due form of law that the foregoing Consent is his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

RICHARD V. JOHNSON

Notary Public

IN THE MATTER OF SHIN EUNG KIM, MD BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Order

By letter dated Dec. 8, 1978, Shin Eung Kim, MD (the "Respondent") through his attorney, John H. Doud III, Esquire, petitioned for reinstatement of his license to practice medicine and surgery in Maryland. As a result of that request the Commission on Medical Discipline of Maryland (the "Commission") met with the Respondent and his attorney on Jan. 2, 1979 to consider that request. Based on that meeting and the materials presented, the Commission makes the following findings of fact.

1. That by Order dated Feb. 10, 1978, the Respondent's license to practice medicine and surgery in Maryland was revoked.

2. That the Feb. 10, 1978 Order provided that the revocation would be stayed upon certain conditions.

3. That Dr. Kim consented to the entry of the Feb. 10, 1978 Order.

4. That Dr. Kim entered a training program at the Robinson Memorial Hospital in Ravenna, OH which program was approved by the Commission.

5. That by letter dated Dec. 27, 1978, D. B. Fraatz, MD, Director of Medical Education, Robinson Memorial Hospital, Ravenna, OH, advised the Commission that the Respondent's performance in the approved residency program was satisfactory and that in his opinion the Respondent is a competent general practitioner.

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6. That by letter dated Dec. 1, 1978, the Respondent was advised that he had successfully completed the American Board of Family Practice certifying examination which he took on Aug. 26-27, 1978, and that he is now a Diplomate of the American Board of Family Practice.

Upon the foregoing findings of fact, it is this 2nd day of January, 1979 by the unanimous vote of the members of the Commission on Medical Discipline hearing this case

ORDERED that the Feb. 10, 1978 revocation by the Commission of the Respondent's medical license is hereby stayed and Respondent is hereby placed on probation upon the following condition:

1. That the Respondent shall submit to reviews of his practice by the Allegheny County Medical Society, such reviews to be conducted six and eighteen months following the date of this Order;

ORDERED that if the Respondent violates the aforesaid condition of probation or if a report submitted to the Commission by the Allegheny County Medical Society following a review of his practice indicates that he is not practicing medicine in a competent fashion, upon notification by and a hearing before the Commission, the aforesaid stay of the revocation of the Respondent's medical license may be withdrawn, and be it further

ORDERED that two years from the date of this Order the Commission will entertain a petition to reinstate Respondent's medical license without any restriction or condition whatsoever; and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with Maryland Code, Article 43, Section 130(n).

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

IN THE MATTER OF KARL K. NAMVARY, MD BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention pursuant to the provisions of Article 43, §130 of the Annotated Code of Maryland, the Physician/Patient Relations Committee of the Medical and Chirurgical Faculty, the state medical society, and the Harford County Medical Society conducted investigations into the medical practice of Karl K. Namvary, MD (the "Respondent"). Thereafter, the Commission on Medical Discipline of Maryland (the "Commission") after considering the reports and recommendation submitted, determined to charge the Respondent with violation of the following subsection of Article 43, §130(h):

(4) The physician has been charged with a crime involving moral turpitude, and has entered a nolo contendere or guilty plea or has been convicted of the crime.

Appropriate notice of the charge and the ground from which it arose was given to the Respondent and a hearing on said charges was held on Jan. 16, 1979. The following members of the Commission were present at the hearing: John E. Adams, MD; Jerome J. Coller, MD; Vincent J. Fiocco, Jr., MD; Arthur T. Keefe, MD; Eli M. Lippman, MD; Karl F. Mech, MD and Francis C. Mayle, Jr., MD. John E. Adams, MD presided as Chairman of the Commission. Also present were Jack C. Tranter, Assistant Attorney General, to advise the Commission as to rules of evidence, and Stephen J. Sfekas, Assistant Attorney General to present the case on behalf of the Commission. The Respondent appeared represented by Russell J. White, his counsel.

Following introductions, Mr. Sfekas proceeded to present the case on behalf of the Commission. After introducing the following documentary evidence, Mr. Sfekas rested the Commission's case:

State's Exhibit No. 1—Certified copies of the docket entries in *State v. Karl K. Namvary*, Circuit Court for Harford County, MD, Case 5952.

Mr. White then proceeded to present the case on behalf of the Respondent. Testimony was heard from the Respondent, Edward J. Simon, MD and a proffer as to the testimony of Frederick J. Hatem, MD was verified by a telephone call placed by Eli M. Lippman, MD, a Commission member. The following documentary evidence was also produced:

Respondent's Exhibit No. 1—Packet of 51 letters (originals and copies) from physicians and other health care providers regarding the Respondent.

Following closing arguments, at the Commission's request, Mr.

White agreed to furnish the Commission with a copy of the transcript of **State v. Karl K. Namvary**, Circuit Court for Harford County, Maryland, Case No. 5952, for review by the Commission. After this discussion, the hearing was concluded.

Findings of Fact

The Commission finds:

1. That the Respondent was convicted in the Circuit Court for Harford County, MD of 38 counts of the crime of false pretenses (Article 27, Section 140 of the Annotated Code of Maryland).
2. That on May 5, 1978, the Court of Special Appeals affirmed the Respondent's conviction.
3. That the Respondent is Board certified in his specialty and appears to be a competent practitioner.

Conclusions of Law

Based upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the Respondent's conviction of 38 counts of the crime of false pretenses is a conviction of a crime involving moral turpitude. Accordingly, the Commission adjudicates Respondent **GUILTY** of that charge.

Order

From the foregoing Findings of Fact and Conclusions of Law, it is this 6th day of March, 1979, by the unanimous vote of those members of the Commission hearing this case:

ORDERED that the license to practice medicine and surgery heretofore issued to the Respondent by the Board of Medical Examiners is hereby **REVOKED** and be it further

ORDERED that the aforesaid revocation shall be immediately **STAYED** with the Respondent placed on **PROBATION** subject to the following conditions:

1. That the Respondent shall provide eight hours of free service per week for a period of 52 consecutive weeks in a manner and at a medical facility designated by the Commission,
2. That the Respondent shall satisfactorily perform the aforementioned free medical services.
3. That the Respondent shall submit written evidence suitable to the Commission that the aforementioned free medical services are being satisfactorily performed.
4. That the Respondent shall begin the provision of the aforementioned free medical services within four weeks from the date the Commission designates the place for and manner of the provision of such free medical services.
5. That the Respondent shall not engage in activities of the type that led to his criminal conviction.
6. That the Respondent's practice shall be in accordance with those standards expected from a competent practitioner of medicine in the State of Maryland; and be it further

ORDERED that if the Respondent violates any of the foregoing conditions of probation, the Commission may, after notification and a hearing, withdraw the stay of the revocation of his medical license or impose any other disciplinary sanction it deems appropriate and be it further

ORDERED that the Respondent's probationary status shall continue for a period of five years after which the Respondent's license shall be automatically reinstated without any condition or restriction whatsoever, if he successfully completes the terms of his probation. In that regard, following the satisfactory completion of the aforementioned free medical services by the Respondent, the Commission will entertain a petition to terminate the Respondent's probationary status and to reinstate his medical license without any restriction or condition whatsoever and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with the Annotated Code of Maryland, Article 43, Section 130(n).

JOHN E. ADAMS, MD

Chairman
Commission on Medical Discipline

☐

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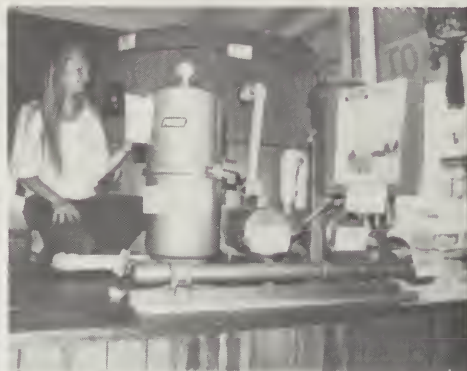
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Medical Miscellany

Motorcyclists Urged to Wear Safety Helmets

Motorcycle crash deaths are increasing sharply in the wake of at least 23 states overturning laws requiring riders to wear safety helmets, the American Medical Association pointed out recently.

All motorcyclists should wear properly fitted, full-facial coverage helmets, the AMA has advised the American public. This policy was reaffirmed by the AMA's House of Delegates in a report adopted at the Annual Convention in June, 1979 in St. Louis, MO. Moped riders should also wear helmets, the AMA urged.

The report originated in a conference on head protection for the cyclist held by the AMA last year in Washington, DC.

With increased helmet usage in the 1960s, head-related fatalities among motorcyclists dropped 40%, but the Highway Safety Act of 1976 removed the authority of the US Secretary of Transportation to require mandatory use of helmets. Consequently, many states repealed their helmet laws, and fatalities have now risen precipitously, to some 4,000 each year, the AMA has pointed out.

Opponents of mandatory helmet laws have maintained that helmets restrict vision and impair hearing. Neither contention has been found valid, the AMA declared. The full-facial coverage helmet allows peripheral vision of 180°, well above the 140° that most states require for licensure to drive an automobile. There is no scientific evidence to support the contention that the helmet dangerously impairs hearing, the AMA said, pointing out that the loud noise of the motorcycle itself blocks out most other sound.

Since the advent of the motorcycle, physicians and researchers interested in reducing death and injury from motor vehicle crashes have been concerned about the tremendous number of fatalities and serious head injuries resulting from motorcycle crashes, the AMA House of Delegates declared.

In recent years, this concern has been intensified because of the significant rise in numbers of cycles, following the introduction of lighter, less-costly vehicles and their use as an economical means of transportation in the current energy crisis.

About 80% of motorcycle crash injuries are to the head, and the chance of being killed is two-thirds greater for the unhelmeted cyclist, the AMA said.

A copy of the AMA conference report, **Head Protection for the Cyclist**, can be obtained without charge from the AMA, 535 N. Dearborn St., Chicago, IL 60610. □

New Directory of Physicians Scheduled for Publication

The 27th Edition of the **American Medical Directory** is available, the American Medical Association reports.

The 27th Edition was published in 1973.

The five-volume edition is the official AMA re-



(Photo by Claude Brooks, Baltimore.)

source of biographical and professional data on the 445,000 US physicians. The **Directory** contains professional and demographic data on each physician, including residents (doctors in postgraduate training). Listings include full name, address, year of license, school of medical education and type of practice, with primary and secondary specialties and specialty board certificates.

The **Directory** may be ordered, for \$225, plus \$4.75 shipping costs, from: PSG Publishing Co., Inc., 545 Great Road, Littleton, MA. 01460. Further information is available from the AMA's Department of Federation Communications, AMA Headquarters, 535 N. Dearborn St., Chicago, IL 60610. □

Americans Entering New Era of Melancholy

America may be entering a new era of melancholy just like the Middle Ages, says a recent AMA report.

Danielle Turns, MD, Associate Professor of Psychiatry at University of Louisville, said the prevalence of affective illness appears to be rising and probably 17% of the US population suffers from it at present.

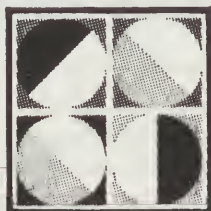
The chance of someone who lives to age 70 contracting depression during his or her lifetime is now 7.8% for males and 20% for females, Dr. Turns said. She speculated that such factors as increased personal expectations with accompanying greater disillusionment if the expectations are not met may be at the root of the increase. But it would be unusual if a person did not experience occasional minor degrees of depression, she said.

Prevention has not been successful for mental illness, Dr. Turns declared. Heredity, personality type and early life experiences all are involved. More females than males suffer from it, by a ratio of three to one.

It is frequently difficult to determine if emotional illness results from or causes a major life change, she said. A patient may lose a job and become depressed; conversely, depression and poor work performance may cause unemployment. □

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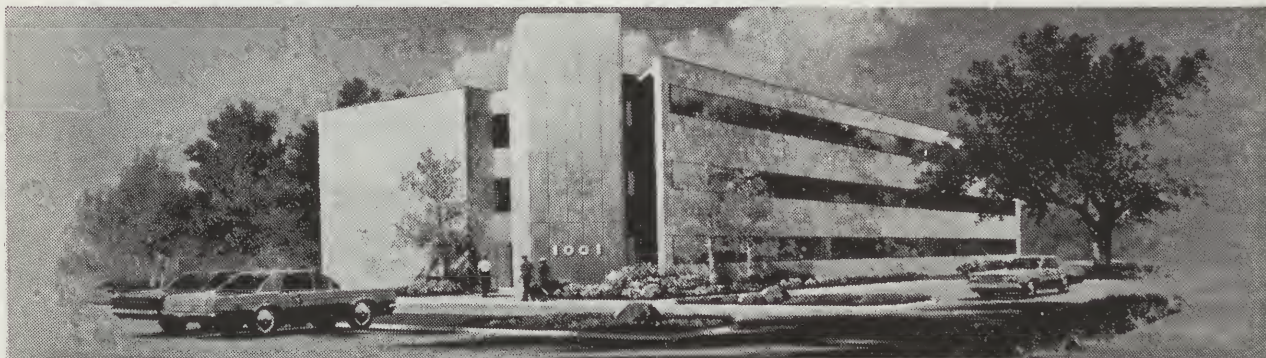
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TOPICS OF INTEREST —

Surgical Judgment in Emergency Surgery for Blunt Trauma With Associated Medical Pathology: Case Reports

By AMI ASZODI, MD; R.A.M. MYERS, MB ChB (Witwatersrand) and FRCS (Edinburgh) and RA. COWLEY, MD

For reprint and other data, contact Dr. Cowley at the Maryland Institute for Emergency Medical Services (MIEMS), 22 S. Green St., Balt., MD 21201.

Summary

This paper addresses the dilemma facing the trauma surgeon when an expected medical condition or developmental anomaly is discovered during the routine workup and treatment of blunt abdominal trauma. Variable conditions are discussed and management of each outlined. The final decision which requires good judgment rests with the operating surgeon.

Introduction

The patient population treated at the Maryland Institute for Emergency Medical Services, (MIEMS) are almost exclusively post-trauma victims. The majority of these patients are due to blunt trauma as a result of automobile traffic accidents. The mini-laparotomy with peritoneal lavage has been used as the primary method of diagnosing hemoperitoneum.

Incidental surgical procedures during laparotomy are well recognized and highly controversial. These may be related to surgical technical error, e.g.; splenectomy, result of spleen laceration in vagotomy or gastric surgery. They can be unrelated, but with some possible later benefit, such as appendectomy, cholecystectomy or Meckel's diverticulectomy.

Five patients with blunt abdominal trauma, all requiring laparotomy for hemoperitoneum with complicating medical diseases or anomalies, are presented with discussion of the dilemma confronting the surgeon.

Patient Reports

A 25-year-old male was involved in a motorcycle accident with blunt abdominal and lower limb trauma. Mini laparotomy revealed a hemoperitoneum. As-

sociated injuries included bilateral mid-shaft femur fractures. Blood pressure was 105/75, pulse 130, hemoglobin 10.8 gm.%. Past history revealed chronic active hepatitis, confirmed by liver biopsies over the past 10 years. Drug therapy consisted of Imuran (Azathioprine) and steroids. On two occasions, he had endoscopically proven, bleeding esophageal varices extending from the mid-esophagus to gastric cardia.

At laparotomy, a ruptured enlarged spleen was found with over 500 cc's of free blood in the peritoneal cavity. Dilated collateral veins were evident around the stomach, liver, anterior abdominal wall and omentum. A firm, greenish, discolored but not macroscopically nodular cirrhotic liver was present. The fractured

spleen was resected and the splenic vein was preserved and dissected off the pancreas. An end to side spleno-renal shunt was performed with a pressure drop of 19 cm. H₂O post-shunt. Preoperative pressure was 37 cm. H₂O and postoperative pressure was 18 cm. H₂O. Liver biopsies were taken from multiple sites. The fractured femurs were plated during the same operation. Post-operatively, his bilirubin levels rose to 35 mg.% but by discharge had fallen to 19 mg.%. Five months after surgery, he died from liver failure. At postmortum, the shunt was patent.

Comment

The general surgical literature indicates that after the first documented variceal bleeding in patients with portal hypertension, an elective portosystemic shunt should be undertaken.¹

Orloff² showed that 93% of variceal bleeding not submitted to shunting procedures re-bled. Of these cases, 74% died from subsequent hemorrhage. Properly performed patent portal systemic shunts will protect 90% of patients from subsequent variceal bleeding.¹

The incidence of post-shunt protein-related portal systemic encephalopathy is lowest in spleno-renal shunts;¹ however, this type of shunt does not decompress the portal bed as efficiently as a portocaval shunt and has an associated 19% recurrence of bleeding and thrombosis.³

This patient had been prepared for an elective portocaval shunt prior to the accident. As a direct consequence of the injury, the ruptured spleen could not be used and thus the distal Warren type of shunt could not be undertaken. Rather than lose the splenic vein from thrombosis, it was felt that the spleno-renal shunt would be technically the least invasive and time-consuming and the easiest and most effective shunt to perform. Should thrombosis occur, other shunts could still be undertaken.

The insult of extensive trauma with multiple in-

juries, severe bleeding into the fracture sites, shock and hypoxia all portended a complicated post operative period in an already compromised (cirrhotic) patient. Blood transfusions, hypoxia and drugs intra- and post-operatively could further strain the disturbed liver function. Thus, with the problem of losing the splenic vein post-splenectomy (through thrombosis) and the increased stress on the liver, it was elected to do the shunt as part of the emergency procedure.

Macpherson and Goddard⁴ have shown that lienorenal shunts are followed by significantly less recurrent bleeding and a longer survival rate than by splenectomy alone. The duration of survival rate after each operation was significantly influenced by the severity of the hepatic dysfunction at the time it was performed.

A 36-year-old male was involved in a motor accident sustaining blunt abdominal trauma and a whiplash neck injury. Cervical spine X-rays showed a fractured C-3 and C-4 with minimal displacement without neurological involvement. Blood pressure was 100/80, pulse 108, hemoglobin 13.2 gm.%, white count 18,200 and platelets 365,000. Mini-laparotomy revealed a hemoperitoneum. Family history, revealed evidence of hereditary spherocytosis. Peripheral blood smear supported this diagnosis.

Cervical traction with Halo Crutchfield thongs traction frame was applied before submitting the patient to laparotomy. A small, two mm. shallow capsule laceration of the spleen was found with some 100 cc's of blood in the peritoneal cavity. There was no active bleeding at the time. A splenectomy was performed and the post-operative recovery was uneventful. Spherocytosis was confirmed by osmotic fragility tests in the postoperative period.

Comment

The operative mortality rate of splenectomy for rupture of the spleen alone due to non-penetrating injury varies from 0-20%. Shirley's⁵ series showed an overall mortality of 9-22% for isolated injury. Mortality rate is proportional to the number of associated injuries and can reach up to 60% when five associated organs were injured.⁶

In children, it has been shown that postsplenectomy systemic infections, especially pneumococcal, are significant.⁷⁻⁸ The overwhelming sepsis post-splenectomy in children with Hodgkin's disease was up to 20% with a 50% mortality.⁹

With minimal splenic injury (Patient #2), it may have been possible not to remove the spleen and a strong argument can be made for this course of action in a hematologically normal person;¹⁰⁻¹² however, it was felt that removal of the spleen would effect a cure for the diagnosed spherocytic anemia. Hereditary spherocytosis or familial acholuric jaundice is the most common type of congenital hemolytic anemia of those of European descent. It affects both sexes equally and is due to a Mendelian dominant inheritance. The intrinsic problem is an abnormality of erythrocytes resulting in a spherical shape with increase permeability of the cell membrane to sodium and a loss of surface lipid. The spherocytes are selectively trapped in the splenic pulp.

The treatment of the condition is splenectomy, unless completely asymptomatic and a fully compensated hemolytic state exists. There is, however, an increased risk of gallstones. The splenectomy will abolish hyperhemolysis and cure the anemia, but does not affect the spherocytes.

Today the role of the spleen in infection control in adults is not clearly understood. Time may prove a similarly important role in adults as it has in children.

A 26-year-old male suffered blunt lower chest and abdominal trauma from a steering wheel motor vehicle accident. He demonstrated respiratory distress with a PaO₂ of 65 mm. Hg. and PaCO₂ of 52 mm. Hg., pulse 116 and blood pressure 100/75. There was marked left-sided upper abdominal tenderness and a positive mini-laparotomy for blood. Hemoglobin 11.2 gms.%, white count 11,000, platelets 350,000. A chest tube was inserted in the left side preoperatively. Laparotomy revealed a ruptured spleen and narrow-necked Meckel's diverticulum. Splenectomy was performed. Because of the unstable condition of the patient with pulmonary contusion, it was elected not to perform a diverticulectomy although with a narrow neck and the possibility of ectopic gastric mucosa, there was the potential for post-operative complications.

The postoperative course was relatively uneventful with four days of ventilation on positive expiratory pressure (PEEP) of 10 cm. for the pulmonary contusion. Daily serial blood gases indicated a definite improvement in the lung contusion. A postoperative technetium scan was suspicious for ectopic gastric mucosa. He was laparotomized three weeks later and a Meckel's diverticulectomy and appendectomy were performed. The postoperative period was uneventful.

Comment

Meckel's diverticulum is not a benign anomaly. The average mortality is about 6 percent,¹⁻¹¹ most of this in the elderly. Complications are much more likely in childhood than later and consist of the following groups: inflammatory peptic, obstructive, umbilical and tumor. In the peptic group, acute perforation may result with localized abscess or generalized peritonitis. Hemorrhage may be severe and is always acute, but chronic anemia from occult bleeding is rarely seen; 90% have ileum lining, 10% may have gastric, duodenal or colonic mucosa or pancreatic tissue. In reported series, bleeding is the most common complication (50%).^{1,11,13} Complications are relatively uncommon, but the diverticulum is a potential source of danger to the patient and should be excised whenever possible.^{1,11}

An unstable intraoperative respiratory condition due to pulmonary contusion made the extension of the operative time unwarranted. A later technetium scan showed the presence of gastric mucosa in the diverticulum and an elective diverticulectomy was performed after due consideration to the complications of a second anesthesia, a recovering contused lung and bowel resection with anastomosis.

A 19-year-old male was involved in a motorcycle

accident with blunt abdominal trauma which produced a positive mini laparotomy. Radial artery cannulation was used for monitoring as it was technically not possible to cannulate the femoral vessels. (Routine femoral artery catheterization is used here for patient monitoring.)

Associated injuries included a fracture of the distal third of the left clavical with an upper root brachial plexus injury (Cervical 5 and 6) and multiple lacerations of the limbs.

At laparotomy, a laceration of the liver was found. It was also noted that aortic pulsations were reduced. Femoral pulses were weaker than the radials. Because of concern of a ruptured thoracic aorta (high speed motor accident) amniography was undertaken immediately on completion of the laparotomy. This revealed a coarctation of the thoracic aorta at the level of T-4 with no evidence of rupture. No further surgery was undertaken. The patient was scheduled for elective surgery, but has been lost to follow-up.

Comment

The most satisfactory age for operating on a coarctation of the aorta is between age 6-16 years. As the patient's age increases, the operation becomes technically more difficult due to a less elastic and more sclerotic aorta. There are more aneurysms of the intercostal arteries and a fixed type of hypertension responding less after the relief of the aortic obstruction. The operative risk rises from 7% in the 6-16 year group to over 10% in older patients.¹ Routine diagnostic studies led to the detection of the disease allowing relatively early correction.

Twenty-four hours prior to admission, a 21-year-old male suffered blunt abdominal trauma after a fall. Due to language difficulty, the history was inadequate. The patient appeared to have severe upper abdominal tenderness with board-like rigidity and on X-ray free air under the diaphragm. A tentative diagnosis of perforated duodenum was made. Temperature 103.4 degrees F., pulse 130, respiration 38 and BP 202/96, Hb 17.4 gms. percent and WBC 12,900.

At laparotomy, a perforation of the mid-jejunum was found with two liters of intraperitoneal intestinal fluid. Also discovered was an incomplete rotation of the midgut with the appendix lying posterior to the right lobe of the liver. The perforation was repaired, an appendectomy performed and the peritoneal cavity well irrigated before closing.

Postoperatively, he was treated with antibiotics and developed a cystic collection of fluid in the pelvis. This was aspirated and found on culture to be sterile. He was discharged after two weeks of hospitalization.

Comment

Hewitt et al¹⁴ determined that in early childhood almost one person in six could be expected to undergo primary appendectomy for suspected appendicitis. Lawrence et al¹⁴ showed that the expectation of appendicitis in a person 28 years old is 1:18. Justification of the appendectomy obviously assumes that the satisfactory condition of the patient will not be compromised by

additional operative time and theoretical risk of contamination. Appendectomy is part of the treatment for malrotation. The diagnostic problems of a malpositioned appendix with subsequent compromise to the patient's life from misdiagnosis are well appreciated.

Conclusion

The trauma surgeon is often face with difficult, and at times, controversial decisions during his surgical endeavors to reasonably and responsibly treat patients suffering from blunt abdominal trauma. Five patients were operated upon with a varied assortment of unexpected or complicated disease conditions.

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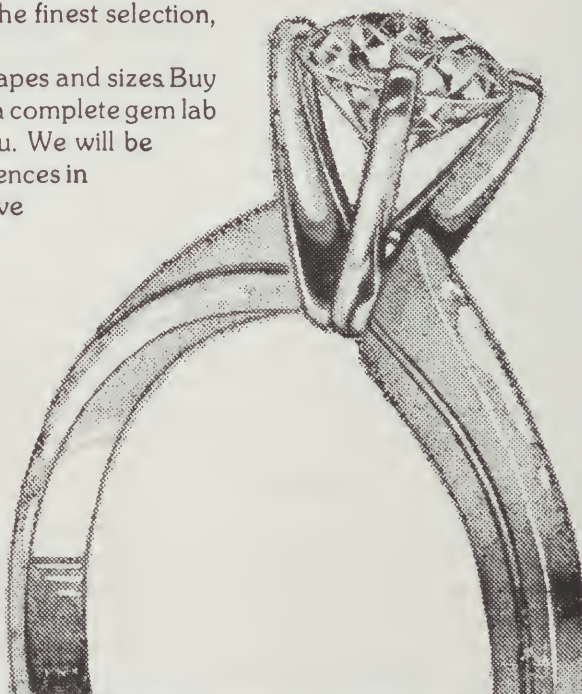
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Maryland Hospital News

Sports Medicine Center Opens at Union Memorial

Union Memorial in Baltimore has announced the opening of its Sports Medicine Center. Under the direction of **William H. B. Howard**, MD, the Center is comprised of medical and educational components designed to provide treatment of and information about athletic injuries.

The hospital, surrounded by numerous schools, universities, Memorial Stadium and residential communities, has always been a focal point for the treatment of a wide variety of athletic injuries. For many years, however, sports medicine problems have been treated in various areas of the hospital by numerous physicians, but without overall coordination.

Most athletes and their coaches want immediate care so that the injury is not aggravated and the athlete can return either to competition or to the pursuit of his/her athletic activities as soon as possible. Union Memorial's Sports Medicine Center has centralized all of its specialists and facilities in one area to expedite care of the injured athlete.

The Sports Medicine Center Clinic is held at the hospital on Mondays and Thursdays from 3-5 PM. Patients may be self-referred or referred by their physician, school, coach, trainer, etc. The purpose of the Center is not to replace private or team physicians, but to assist them.

Students, sports enthusiasts, joggers and weekend athletes of all ages will find a full range of services available including evaluation, treatment and follow-up from the Clinic's staff. Members of the staff have particular interest in sports medicine and have lectured and written exclusively on the subject. At every session are attending physicians in general surgery, orthopedic surgery and radiology. Nurses and physical therapists are present to assist in the treatment of the athlete. Cardiologists and gynecologists are on call, should

their consultation be needed. Diagnostic tests such as X-rays and laboratory studies that are needed are performed on the same day. The injured athlete has the benefit of all of these specialists and tests during the same visit.

At the end of the visit, Center physicians explain the diagnosis and suggest treatment to the patient. In addition, recommendations are given for return to activity and follow-up visits, if necessary.

Registration for the Sports Medicine Center is in the hospital's Emergency Department on Calvert St. at 34th St.

The Sports Medicine Center will feature educational programs throughout the year. Last year, Union Memorial cosponsored an all-day Sports Medicine Seminar with the Johns Hopkins University, featuring physicians, coaches and trainers from all over the country.

For further information or scheduling of appointments at the Union Memorial Sports Medicine

Center, call (301) 235-7200, Ext. 2253. □

UMH Doctors Receive Award

John N. Classen, MD, Vascular Surgeon, and **A. Allan Genut**, MD, Neurologist, were recently presented with the Union Memorial Hospital Golden Apple Award, which was developed by the Hospital's House Staff to honor attending physicians for excellence, effort and enthusiasm in teaching. Drs. Classen and Genut are the recipients of the first Golden Apple Awards.

For the last three decades, Dr. Classen has been in integral part of the surgical training program at the Hospital and has served as Chief of Surgery.

The House Staff explained that Dr. Classen was tireless in his teaching efforts and never too busy to give assistance. In the Emergency Department, Vascular Clinic and Diabetic Foot Clinic, he was available for consultation and freely gave residents the benefits of his



RODNEY SCHLEGEL, left, and **Dr. WILLIAM HOWARD**, Medical Director of the Sports Medicine Center at UMH, examine the ankle of a SMC patient.

years of experience. Besides his affiliation at UMH, Dr. Classen is also an Assistant Professor at the Johns Hopkins Hospital School of Medicine.

Dr. Genut came to UMH in 1975 after serving as Chief Resident in Neurology at University Hospital in Baltimore, and is Chief of the Neurology Section in the Department of Medicine.

In accepting the award, he stated that it was "The biggest honor of my life." Dr. Genut said that he considers himself to be both a teacher and physician. No one doubts this observation, especially if you count the endless hours he has spent trying to explain the mysteries of neurology to the House Staff.

Soft-spoken and usually surrounded by a cloud of pipe smoke,

Dr. Genut was singled out because of his "Presenting excellent teach-

ing conferences" and his "teaching around the clock." □

Coming in the Journal:

Symptomatic Splenic Secondary Cyst: A Case Report and Review of Literature

by Yu-Wen Chang, MD

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Dr. A. ALLAN GENUT receives Golden Apple Award from Dr. MICHAEL N. RUBINSTEIN, a member of the Union Memorial Hospital House Staff.



Dr. ROBERT DAVIS (left) presents the Golden Apple Award to Dr. JOHN N. CLASSEN. Dr. Davis is a member of the Union Memorial Hospital House Staff.

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Coming in the Journal:

Unusual Survival in Post-Infarction Ventricular Septal Defect Associated With Cardiomyopathy
by W. Robert Lange, MD and Mahmood Ali Khan, MD

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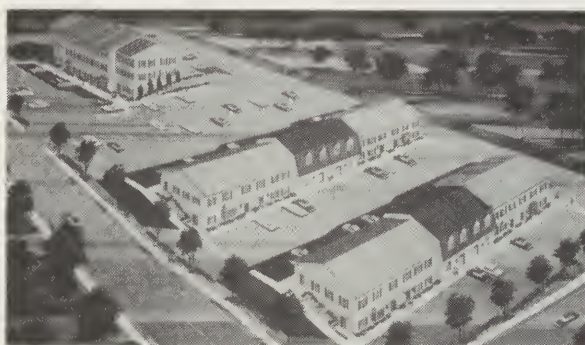


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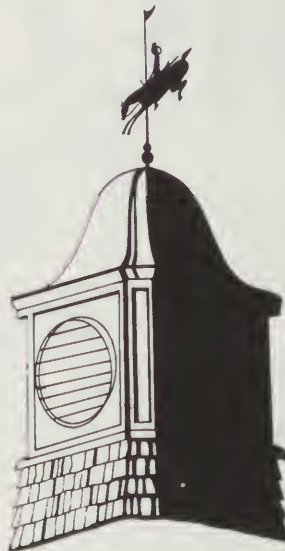
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Dec. 7, 1-4:15 PM, Understanding and Treating Sexual Impotence, Paul Fink, MD. (Philadelphia), 3 hrs., Cat. 1 cred.

Dec. 19, 8-10 PM, Endorphins: The Brain's Own Morphine, Solomon Snyder, MD. (Baltimore, Maryland), 2 hrs., Cat. 1 cred.

Jan. 9, 8-10 PM, Approaches to an Understanding of Delinquency; spkr.: Jos. Noshysitz, MD. Two hrs Cat. 1 cred.

Jan. 18, 1-4:15 PM, Stages in Adult Development; spkr.: Robt. Gould, MD. Three hrs. Cat. 1 cred.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Building unless otherwise indicated. For details call **Dr. Janet Hardy** at (301) 955-5880.

Nov. 10, Cytopathology of Needle Aspirations, presented by Dr. Jenner Erozan, Associate Prof. of Path., JHU Sch. of Med. Cosponsored by MD Assn. of Cytotechnologists and Amer. Cancer Soc., MD Div., Inc. To be held at Knott Sci. Ctr., College of Notre Dame. For details, call (301) 955-3520 for Mrs. Cowles or for Mr. Kirby at (301) 296-3422.

Nov. 15-17, Sexually Transmitted Diseases: An Update.

Nov. 16-17, Progress in Pediatrics: 1979.

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Nov. 29-30, Chronic Disease Epidemiology at the Threshold of a New Decade: A Symposium in Honor of Dr. Abraham M. Lilienfeld.

Dec. 1-2, Surgical Management of Intracranial Aneurysms.

Dec. 1, 7th Annual Geriatrics Symposium.

Dec. 2-4, Lactose Absorption.

University of MD Sch. of Medicine

Nov. 16-17, Symp. on GI Cancer, Internatl. Hotel, BWI Airport. For details, call (301) 528-3956.

Dec. 7-8, Symp. on Gynecologic Oncology, Internatl. Hotel, BWI Airport. For details, call (301) 528-3956.

Miscellaneous Meetings

Nov. 9, Dr. R. O. Y. Warren Mem. Sem., Update '79, Postgrad. Ped. Course, sponsored by and at the Delaware Acad. of Med. 1925 Lovering Ave. and Union Sts., Wilmington, DE. For details, call (302) 654-8757.

Dec. 1, 4th Anl. Crit. Care Conf., Nutritional Management and Metabolic Care of the Seriously-Ill Patient, at Geo. Mason Univ., Fairfax City. For details, call Mrs. Shirley Kerzaya at (703) 698-3785. □

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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows.

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and or clidinium Br

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction. Changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and or low residue diets

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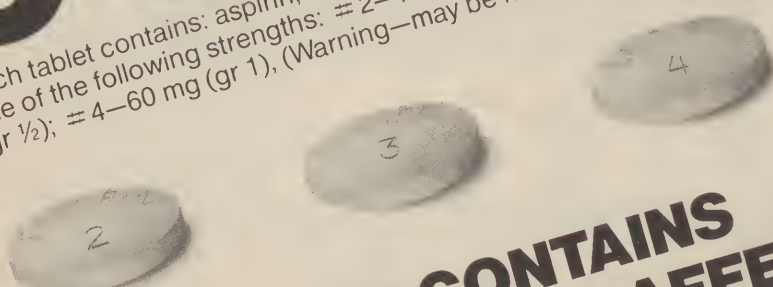
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* Librax has been evaluated as possibly effective for this indication.
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“The correlation of spasm relief and drug given was excellent.”

*This drug has been classified “probably” effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

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Doctors in the News

Dr. Sherman Elected

Michael L. Sherman, MD has been elected President of the Maryland Radiological Society, succeeding **Dr. George Burke**. The Society is the professional organization for the state's radiologists.

Certified by the American Board of Radiology, **Dr. Sherman** holds clinical appointments in the Departments of Radiology at the Johns Hopkins and the University of Maryland Hospitals. He is on the attending staff of Franklin Square and also consults at the James Lawrence Kernan Hospitals.

The Society's new President received his Medical Degree from the University of Maryland, where he also completed his radiologic training.

In 1972, he entered the private practice of radiology with Drs. Copeland, Hyman and Shackman, PA.

Other officers recently elected are **Dr. James E. Bell**, President-Elect; **Dr. Niel Borrelli**, Treasurer and **Dr. Stanford Goldman**, Secretary.

Dr. Gray Named

Herbert A. Kushner, MD, Chief of Medicine at Lutheran Hospital of Maryland, Inc., has named **Darrell M. Gray, MD**, as Assistant Chief of the Department.

Dr. Gray, who is a native of Baltimore, did his undergraduate work at John Hopkins University, followed by medical studies at the University of Maryland and a Residency at University Hospital, completed in 1979.

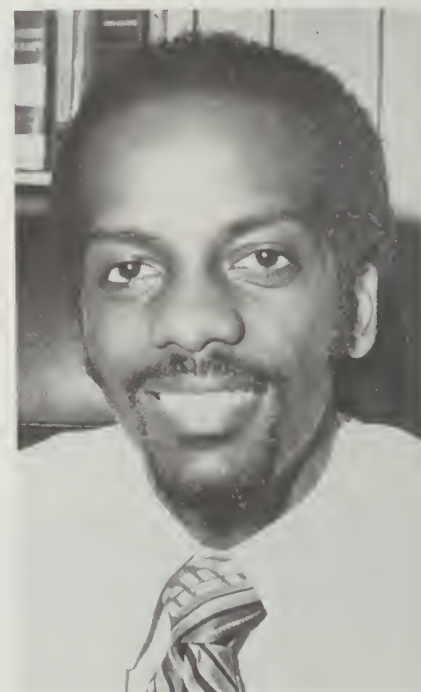
As part of his Residency program, **Dr. Gray** worked to establish an outreach medical clinic in the medically-underserved areas of West Virginia and Cumberland and continues as a consultant to that program.

In addition to his position at Lutheran, **Dr. Gray** is an Instructor of Medicine on the faculty of Primary Care, Internal Medicine, at the University of Maryland Hospital.



DR. SHERMAN

He has spent summers as a Physiology Instructor at the Johns Hopkins School of Medicine and a Research Assistant with the Baltimore City Health Department and the Johns Hopkins School of Hygiene and Public Health.



DR. GRAY

Lectureship Set Up

An endowed annual lectureship in biochemistry has been established at the University of Maryland School of Medicine by **Samuel Steinberg**, MD, Class of 1936, as a memorial to **H. Boyd Wylie**, MD, 1887-1963, who devoted his career to medical education at the University of Maryland, serving as Professor and Chairman of the Department of Biochemistry and as Dean of the School of Medicine.

Dr. Steinberg, a Philadelphia family physician, has established the Dr. Samuel Steinberg and H. Boyd Wylie Lecture so that distinguished individuals may be invited to lecture on the behalf of the Department of Biochemistry. The lectures will deal with future directions in the field.

Dr. Wylie, a native Baltimorean, graduated in 1912 from what was then the Baltimore Medical College, and spent the next 40 years at the School of Medicine, serving in various capacities. As a result of his efforts, a committee on

admissions for the selection of medical students was appointed. He contributed articles on biochemistry to medical journals, and **American Men of Science** noted his work on blood sugar findings in eclampsia and chemical methods for the diagnosis of pregnancy. His work earned him recognition in **Who's Who in America**, membership in Alpha Omega Alpha and a Wiley Day medical library tribute.

Dr. Steinberg, who worked his way through college and medical

school, credits Dr. Wylie with encouraging and persuading him to remain in medical school when financial difficulties threatened to cause him to withdraw.

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Project Grants

The Southern Medical Association is pleased to announce SMA Research Project Fund recipients for the 1979-80 season, and Maryland's recipients are: **Mark P. Carol, MD**, University of Maryland School of Medicine, Neurosurgery, for "investigation of a new type of intraventricular catheter and monitoring system" and **Sheldon H. Lerman, MD**, University of Maryland School of Medicine, Surgery/Gastrointestinal, Physiology "splanchnic nervous control of the pyloric sphincter." □

Medical Miscellany

The Maryland Interdisciplinary Council for Children and Adolescents

The Maryland Interdisciplinary Council for Children and Adolescents, organized by concerned physicians in cooperation with other professionals, represents an important and extremely valuable sustained effort at interdisciplinary education and communication. The goal is the improvement of the manner in which professionals treat or represent their young patients or clients. Moreover, there is a sharing of concern and an endeavor to deal with such issues as the privacy of medical and psychiatric records required by and maintained by the public school system. There are monthly meetings and an annual conference. There are currently 14 professional groups comprising the Council. The professionals include lawyers, pediatricians, family practitioners, psychiatrists, social workers, educators, psychologists and mental health workers. Med-Chi was one of the founding organizations. Other medical groups assisting in organizing and maintaining the Council include the Maryland Academy of Pediatrics, the Maryland Psychiatric Society, the Regional Council of Child Psychiatry, the Maryland Society for Adolescent Psychiatry and the

Baltimore-District of Columbia Institute for Psychoanalysis.

The First Annual Interdisciplinary Conference on Children and Adolescents, held Jan. 27, 1979, was a resounding success. The Conference was over-subscribed and there were 225 professionals in attendance. The topic was **Public Law 94-142 (The Federal Law Regarding Free Education of Handicapped Children)—The Impact on Professionals Working in a Changing System**. A copy of the proceedings will be published, and available without charge, at the next Annual Meeting on Jan. 26, 1980.

The idea for formation of the Council arose in the Child and Adolescent Psychiatry Committee of the Maryland Psychiatric Society. The Council of the Maryland Psychiatric Society had been concerned that there were not enough opportunities for physicians to speak to and exchange ideas with lawyers and other professionals on a cooperative basis and enthusiastically supported the endeavor. The Chairperson has been Theodore H. Kaiser, MD and the Treasurer Louis Bandell, who is also the Treasurer for the Maryland Association for Mental Health, Inc.

The Second Annual Interdisciplinary Conference on Children and Adolescents will be held Jan. 26, 1980 at the Sheppard and Enoch Pratt Hospital. The subject will be the controversial new Juvenile Justice Standards of the Institute of Judicial Administration and the American Bar Association. These standards, if implemented, would replace treatment and rehabilitative efforts for juvenile offenders with determinate sentencing (similar to criminal sentencing). The title of the program is **Proposed Juvenile Justice Standards: Justice to the Offender or Abandonment of Our Youth?**

The Program is approved for 3.5 credit hours of Category I, AMA Continuing Education, and will be held from 9 AM-12:30 PM.

The Conference will discuss the controversial new Juvenile Justice Standards of the Institute of Judicial Administration and the American Bar Association. These broad

range proposals would markedly alter the manner in which we treat juvenile offenders. Among the starkly different consequences, determinate sentencing (similar to criminal sentencing) would replace treatment and rehabilitative efforts. These standards potentially would have an impact on all our youth and the professionals dealing with them. The Conference goal is to provide professional current information with which to understand and assess the new proposals.

The Conference will be addressed by Dr. Ivan W. Laurich, a Psychiatrist from the Medical Office of the Supreme Bench of Baltimore City, Dr. Ulku Ulgur, a practicing Child Psychiatrist; Judge Robert L. Karwacki, Administrative Judge of the Supreme Bench of Baltimore City; Donald H. Saidel, PhD, a psychologist of the Sheppard and Enoch Pratt Hospital and C. Marchal Fuller (MSW), Director of Clinical Services, of the Maryland Training School and Dr. Regina Cicci, language/learning specialist, University of Maryland Hospital.

The Conference is cosponsored by the Maryland Interdisciplinary Council for Children and Adolescents and the Maryland Psychiatric Society. The Council is the first sustained effort in Maryland to bring together a large interdisciplinary group of professionals for the purpose of increased communication and professional education dealing with children and adolescents. It is composed of representatives of the professional societies of 14 groups representing doctors, (including family practitioners, pediatricians and psychiatrists), lawyers, social workers, educators and psychologists through the state.

The registration fee for the Conference is \$7. Interns, residents, students and trainees will not be charged admission. For further information or registration, please contact Dr. Theodore H. Kaiser, Chairperson, MIC-CA, Box 23, Stevenson, MD 21153.

Maryland Academy of Family Physicians



MARYLAND ACADEMY OF FAMILY PHYSICIANS officers were present when Maryland's Gov. Harry Hughes signed a document proclaiming "Family Health Care Week" recently. From the left are Dr. John Umhau, (then) MAFP President-Elect; Gov. Hughes; Dr. Aris Allen; Dr. C. Earl Hill, (then) MAFP President and Dr. Dean Griffin, Program Chairman of the MAFP scientific assembly. (Photo courtesy of **AAFP Reporter**, Kansas City, MO.)

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Maryland Hospital Association Speaking of Hospitals

RICHARD J. DAVIDSON, Editor

New Officials

A Baltimore attorney, a Black and Decker executive, a farmer from Southern Maryland and the president of a Baltimore County chemical firm took office recently as leaders of the Maryland Hospital Association.

The four serve as officers of the Board of Presidents, the governing body of the statewide association of Maryland's 62 community hospitals. They were elected at the organization's annual meeting. All came to their posts as volunteer trustees of their local hospitals.

Elected were Eugene M. Feinblatt of Baltimore, Chairman; Edwin G. Delcher of Timonium, Vice Chairman; B. B. Kemp of Welcome, Treasurer and George M. S. Riepe of Monkton, Secretary.

Feinblatt has been a Baltimore lawyer and civic leader for more than 30 years. He is First Vice President of Sinai Hospital and is the former President of both the Northwest Baltimore Corporation

and the Baltimore Jewish Council. Other civic leadership posts include the boards of the National Housing Conference, the National Community Relations Council and the Baltimore Chapter of the American Red Cross. He has been a trustee at Sinai for the past seven years.

He also has served as Chairman of the Baltimore Urban Renewal and Housing Agency and the Baltimore Regional Planning Council's Area Housing Council. Feinblatt, who earned his bachelor's and law degrees at the University of Virginia and did postgraduate work at Harvard, has taught at both the University of Maryland School of Law and Johns Hopkins University. He was a Professor in that institution's Department of Public Health Administration for three years.

The Senior Vice President and Secretary of Black and Decker, Edwin Delcher has served as a Trustee of Saint Joseph Hospital in Towson for the past four years. He

is on the Board of the Union Trust Company and is a member of the Maryland Association of Certified Public Accountants and the Financial Executives Institute.

MHA's new treasurer, B. B. Kemp, has been a leader in Southern Maryland's agricultural and civic communities for nearly 40 years. A resident of Charles County, he has served on the Board of Trustees of Physicians Memorial Hospital in La Plata for 16 years, presiding as its Chairman for 12 yrs. He was one of the founders of the Southern Maryland Hospital Association and was its first President. Kemp served a two-year term on the Southern Maryland Health Systems Agency Board and has been a Director of the Charles County Farm Bureau for more than 30 years.

George M. S. Riepe is in his second term as MHA Secretary. He is completing 12 years on the Board of Church Hospital in Baltimore. Riepe has been President of the Board of Trustees since 1973 and Chairman of the hospital's Board of Directors since 1974.

The President of the Warner-Graham Company, he earned both the Bronze Star and Purple Heart in World War II and was an All-American lacrosse player during his collegiate days at Johns Hopkins University. His civic activities include work with the United Way, the Heart Association, the Family and Children's Society and the Jaycees. □



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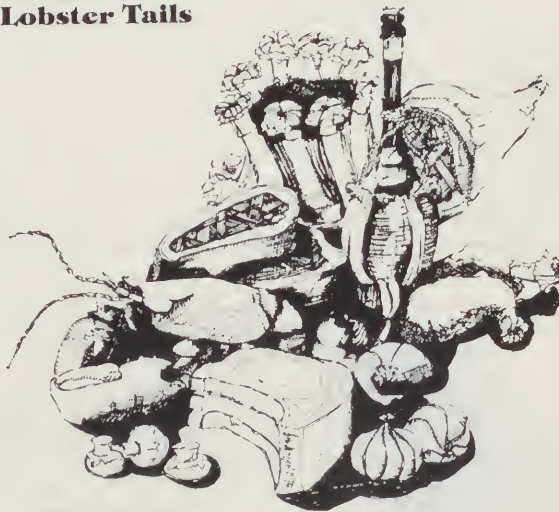
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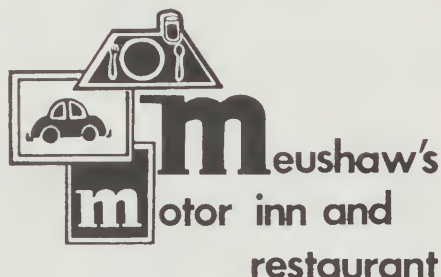
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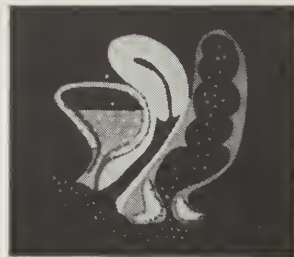
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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



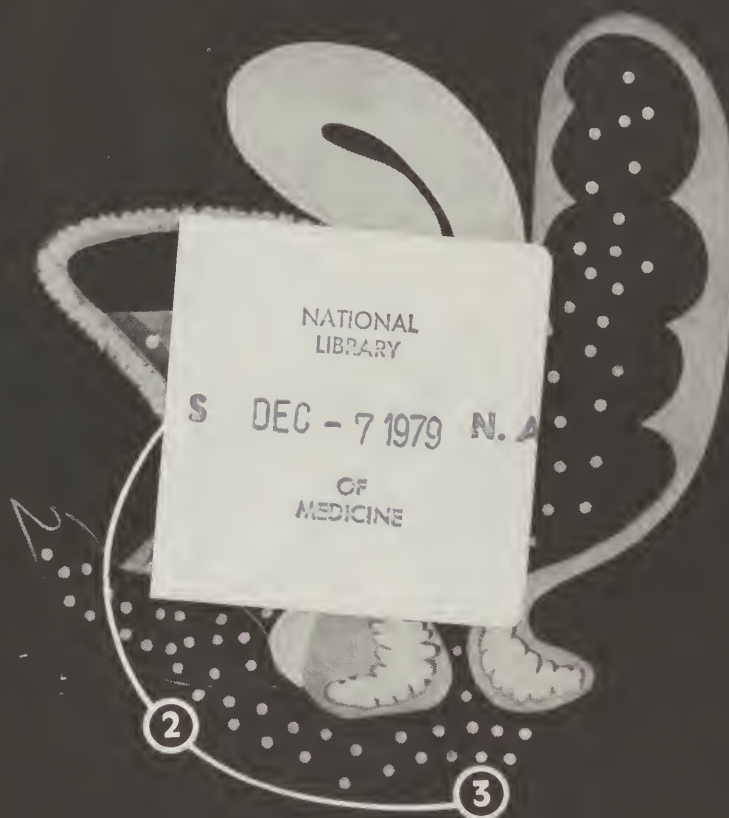
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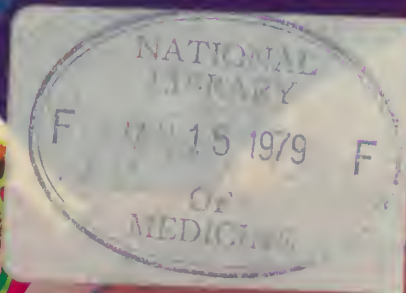
MARYLAND STATE MEDICAL



Journal



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"Nelson... said to his Captain, 'You know, Foley, I have only one eye. I have a right to be blind sometimes.' He is said to have raised his spyglass to his right eye, the one injured... and announced that he could not see the signal to leave off action..."

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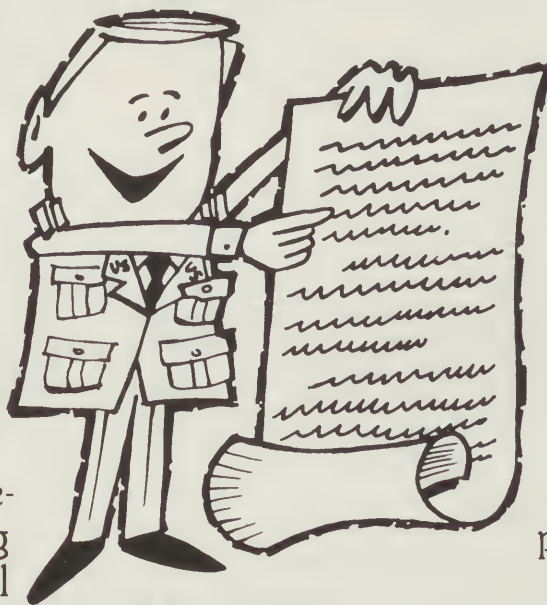
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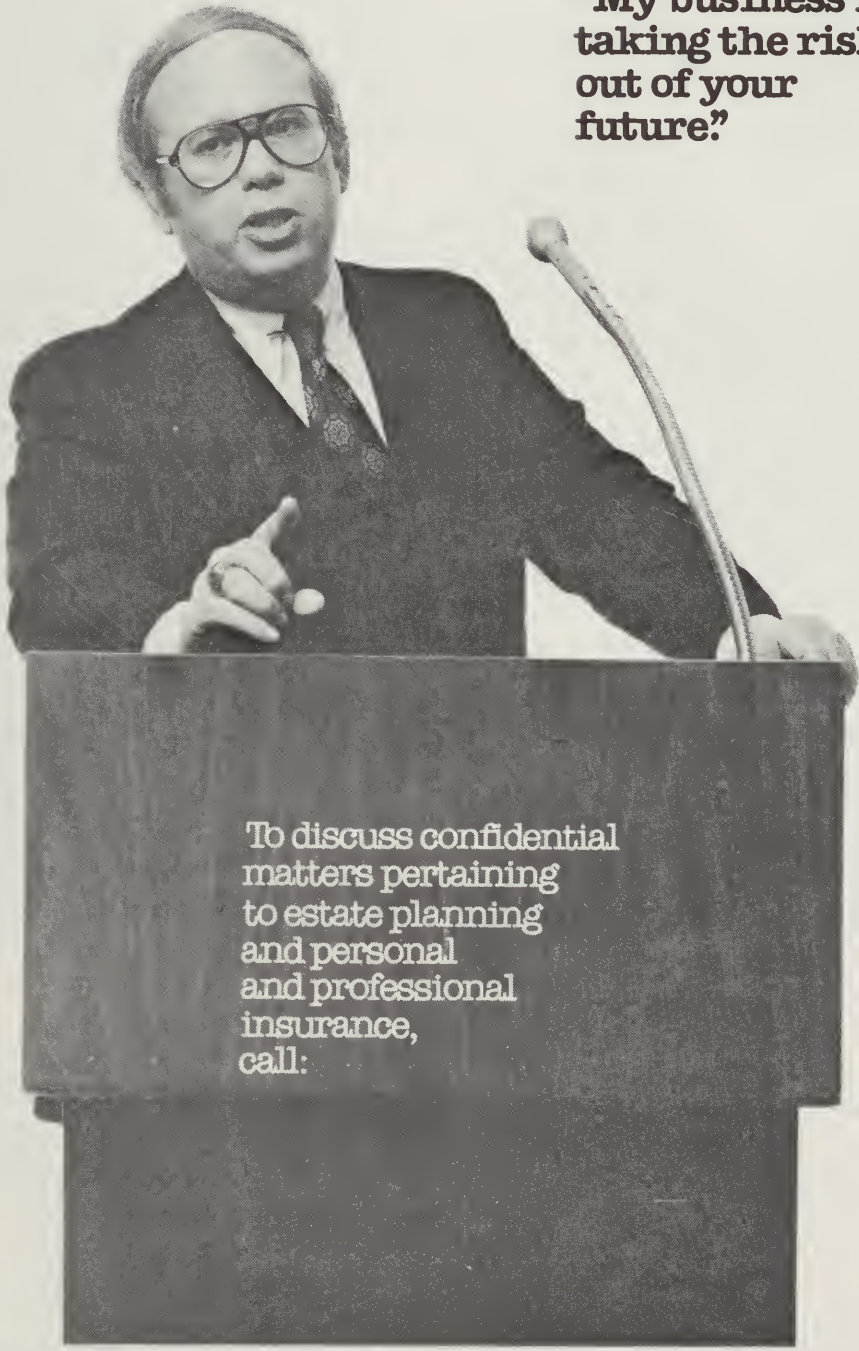
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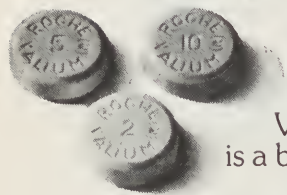
A black and white photograph of Marvin A. Address, a man with glasses, wearing a suit and tie, speaking at a podium. He is pointing his right index finger towards the audience. A microphone is positioned in front of him.

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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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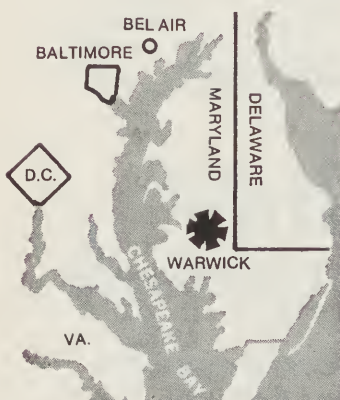


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MARYLAND STATE MEDICAL Journal

Volume 28

DECEMBER, 1979

Number 12

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EDITORIAL and BUSINESS OFFICE:
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Class postage paid at Baltimore, MD.
Accepted at the special rate authorized. Published monthly.
Subscription rates: US, US Possessions, one year \$8; elsewhere \$15. Single Copy, \$1.

The views in this publication are those of the authors and do not necessarily reflect the opinion of the Medical and Chirurgical Faculty of the State of Maryland.

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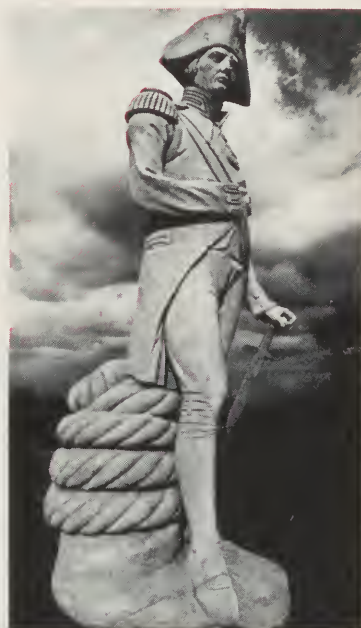
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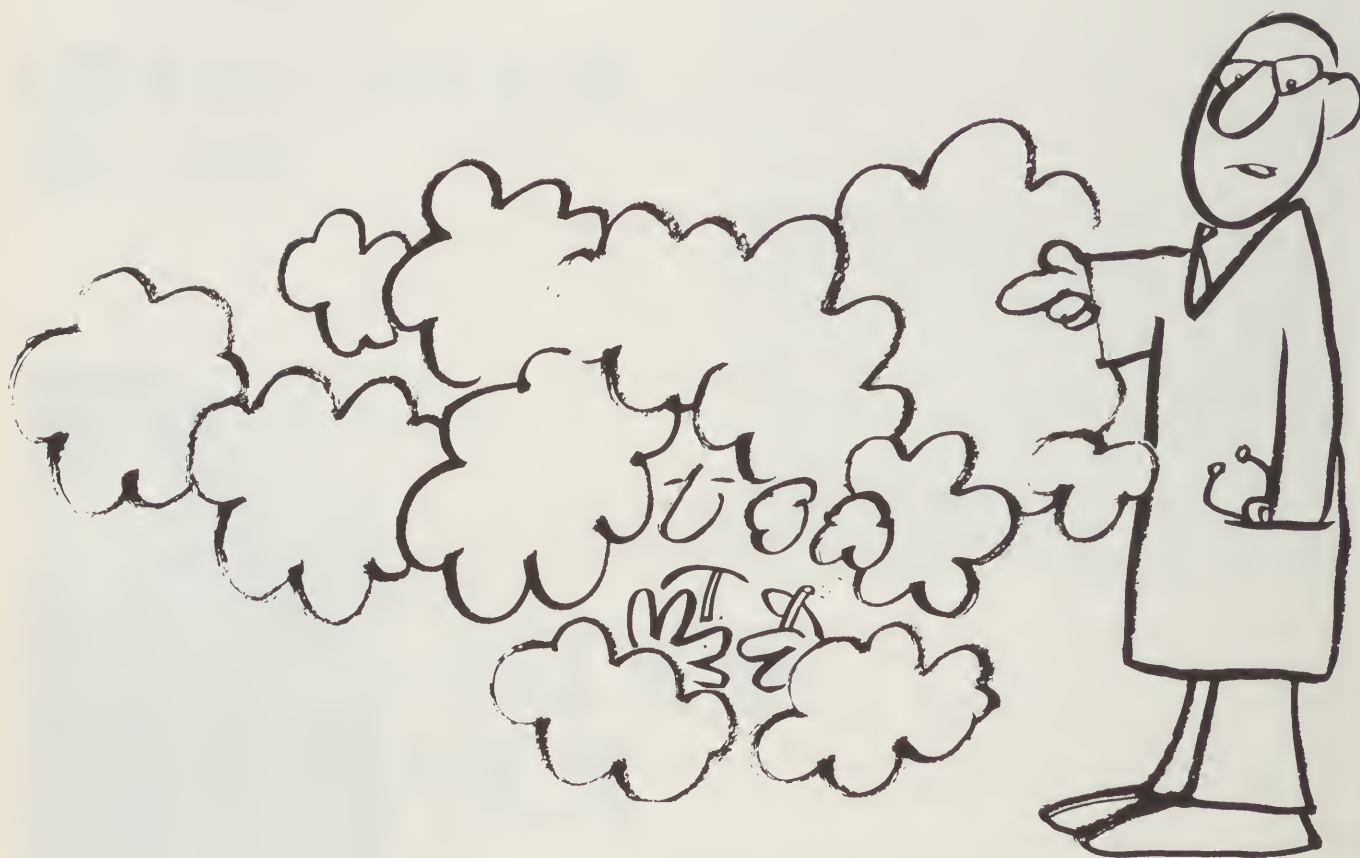
The 18-foot tall statue of Admiral Nelson was erected in London's Trafalgar Square atop a pillar looking toward France in 1843 by sculptor E. H. Bailey. The famed British "sea-dog's" medical case history begins on p. 35 in this edition.

(Cover artwork by Claude Brooks, Owings Mills, MD; design by Blaine Taylor.)

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Don't just tell her to quit...



Studies confirm that 9 out of 10 smokers know that smoking is a bad habit. And they'd like to quit. But they don't know how.

The large majority of smokers indicate they would quit if their doctors told them to.

And studies confirm that a large proportion of patients have quit upon advice from their doctors.

However, about two-thirds of smokers report that they've never received advice on quitting from their doctors. It could be their doctors don't want to push them. Or maybe quitting is given a lower priority than other health problem.

But we believe a lot of doctors don't tell their patients to quit smoking for one simple reason: they don't know how to answer the inevitable "how."

The National Cancer Institute has developed a free "Helping Smokers Quit" kit to help you answer the "how" and to help your patients quit the smoking habit. Materials for this kit were pretested with the cooperation of the Harris County (Texas) Medical Society and M.D. Anderson Hospital and Tumor Institute in Houston, Texas.

The National Cancer Institute will provide the "Helping Smokers Quit" kit free of charge to all physicians who want to participate in this important effort. Included in the kit are guidelines for physicians, a self-test to help smoking patients determine why they smoke, pamphlets with tips on quitting, and waiting room posters to introduce the subject. Each kit contains enough materials to help 50 of your smoking patients who want to quit.

Show her how to quit.

Cigarette smoking remains the single greatest preventable cause of death and disability in the US today. In 1977, smoking was a major factor in an estimated 220,000 deaths from heart disease; 78,000 lung cancer deaths, and 22,000 deaths from other cancers, including cancers of the mouth, esophagus, pancreas, kidney and bladder; 40% of all cancers in males, and a rapidly-increasing percentage in females, are caused by smoking. Eighty-five percent of deaths from bronchitis, emphysema and other lung diseases could be prevented if people stopped smoking.

Fortunately, a recent study has shown that nine out of 10 smokers **want** to quit. The larger majority indicate they would quit if their physicians **told** them to, and studies confirm that many smokers **have** quit upon advice from their physicians; however, about two-thirds of smokers report that they have never received advice on quitting from their physicians.

To help physicians encourage quitting by their patients, the National Cancer institute has developed the **Helping Smokers Quit** kit. The kit contains enough materials to assist 50 smokers who want to quit.

The kit can make a major contribution to your efforts to prevent cancer and other chronic diseases among your patients. The kit is being provided free of charge to all physicians who want to participate in this important preventive health effort.

ARTHUR C. UPTON, MD, Director
National Cancer Institute
National Cancer Program

I don't want to just tell her to quit.
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The recent increasing awareness of diamonds as a possible investment has developed many questions in the minds of potential investors. Our diamond investment consultant and graduate gemologist, Robert L. Smyth, Jr. has the answers to many of these questions and the experience of working with numerous individuals who have pursued diamonds as an investment. If you are interested in learning more, he can be contacted at 252-6666, Monday through Saturday (except Wednesday).



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The Open Forum

Dr. Morris

To the Editor:

The article on **The History of Obstetrics and Gynecology in Maryland, 1770-1976**, published in the September, 1979 edition of the **Journal**, omitted Dr. Frank K. Morris' name.

Dr. Morris was a noble gentleman, a fine physician and an outstanding practitioner of gynecology and obstetrics.

In the article, his name was forgotten. Those who knew him still feel and pay tribute to the homage he deserves for his useful and generous life.

JOSÉ R. ANDREU, MD
12606 Colby Dr.,
Woodbridge, VA 22192.

□

On Sen. Mathias' Comments

To the Editor:

The comments by Senator Charles McC. Mathias, Jr., (R., MD) under Medical Miscellany (September, 1979—ed. note), have accurately defined one of the major causes for not having enough "primary physicians" in Maryland. Perhaps if he would pursue this issue of inequitable reimbursement to family physicians by third-party payors, the people of Maryland would have a lower cost medical system.

I hope others will join Sen. Mathias in his endeavors to accomplish the above task.

MORTON J. ELLIN, MD
DRS. ELLIN AND GARBER, PA
5310 Old Court Rd.
Randallstown, MD 21133.

□



"... Doctor, ... Mrs. Rafferty just dropped in, ... could you, ..."

WHAT DO YOU THINK OF THE JOURNAL?
Let us know! Write Open Forum,
JOURNAL,
1211 Cathedral St., Balto., MD 21201.

Six, Not Two

To the Editor:

Prince George's County has six civilian hospitals, each of which has an Emergency Room. It is quite distressing to us in Prince George's County to see a list of Maryland hospitals which omits four of our hospitals, particularly in a publication such as the **Journal**.

To set the record straight, following is a list of the civilian hospitals in Prince George's County:

Clinton Community Hospital
8910 Woodyard Rd.
Clinton, MD 20735
(301) 868-1500.

Doctors' Hospital of Prince George's County
8118 Good Luck Rd.
Lanham, MD 20801
(301) 552-9400.

Eugene Leland Memorial Hospital
4408 Queensbury Rd.
Riverdale, MD 20840
(301) 864-1200.

Greater Laurel/Beltsville Hospital
7100 Contee Rd.
Laurel, MD 20810
(301) 953-1300.

Prince George's General Hospital and Medical Center
Cheverly, MD 20785
(301) 341-3300.

Southern Maryland Hospital Center
7503 Surratts Rd.
Clinton, MD 20735.

SUSAN B. WATERS
Executive Director
Prince George's County Medical Society
7901 Annapolis Rd., Suite 203
Lanham, MD 20801.

(Managing Editor's Note: The list in question appeared on pp. 80-81 in the **Special Section on Heart Attack** of the September, 1979 issue, and was supplied to the **Journal** by the American Heart Association—Central Maryland Chapter. As a result of Ms. Waters' letter, the list is under revision by the AHA/CMC.—BT.) □

More letters on page 10...

Statement of Ownership, Management, Circulation

Maryland State Medical Journal, published by the Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral St., Baltimore, MD 21201. James G. Zimmerly, MD, Editor; Victor R. Hrehorovich, MD, Associate Editor; Blaine Taylor, Managing Editor. Editorial Offices: 1211 Cathedral St., Baltimore, MD 21201. Owner: Medical and Chirurgical Faculty of the State of Maryland. No known bondholders, mortgagees or other security holders.

Total number of copies printed issue nearest filing date: 6,051; monthly average preceding 12 months: 6,082. Paid circulation through dealers and carriers, street vendors and counter sales, *none*; mail subscriptions and total paid circulation: 5,692; average: 5,724. Free distribution: 209; average: 208. Total distribution: 5,901; average: 5,932. Office use, etc.: 150; average: 100.

Sum total: 6,051; average: 6,082.

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Mercy's Correct Number

Please be advised that the article **Heart Attack** appearing in the September, 1979 issue of the **Journal** contains incorrect information on page 80 regarding the telephone number for Mercy Hospital. The number listed in the article is 727-5400. The correct number is 332-9000.

ALAN BLOSE

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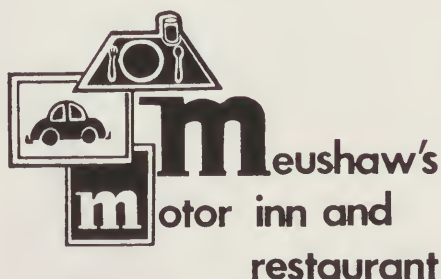
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From Dr. Morrison . . .

To the Editor:

Please consider this an open letter by means of which I wish to convey certain information to your readership.

I should be pleased to see an article under my name in the September, 1979 issue of the **Journal (Medical Annals of Maryland, 1899-1925/Nutrition in Maryland 1899-1928—ed. note)**, but, to be frank, I am not altogether enthusiastic about it for reasons which I would like to make clear.

First, this article was brought together so many years ago that I had forgotten about it and, therefore, I would not like anyone to think it was recently written. Furthermore, I was not given the opportunity to read the proof which would have given me a chance to modify the article, although the essential facts are present as it is printed; however, there are certain errors which I know you will appreciate my calling to your attention. First, the major title is **Medical Annals of Maryland, 1899-1925**. The article under my name is **Nutrition in Maryland, 1899-1928**. Only one reference includes the date 1928. This, perhaps, is not important, but the very first sentence which reads, "Great names appear in the 19th Century as well as in the modern history of nutrition until E.V. McCollum came to Baltimore, the contributions of Marylanders to the field of nutrition were sporadic and only a temporary importance." This sentence is incorrect. At best, it should read, "Great names appear in the 19th Century, as well as in the modern history of nutrition. Until E.V. McCollum came to Baltimore, the contributions of Marylanders to the field of nutrition were sporadic and only of temporary importance." In other words, breaking this down into two sentences makes sense, whereas in one sentence it does not sound grammatically correct. Also, my birthdate is wrong and my professorial status is not correct, and then, without going into too much detail, there are errors in sentence structure and punctuation, which I know would have been corrected if I had been given the opportunity to read the proof. As one more example of what prompts me to write this letter, which I would rather not have been called upon to do, is the last paragraph on page 108 where there seems to have been the omission of a sentence or two.

On a brighter side, and in trying to recall those early years when I was asked to join a group to write the **Medical Annals of Maryland**, I also remember the enthusiasm with which we undertook a task which proved to be quite difficult. As mentioned above, the article, as is, conveys some very notable historical facts, and to that end, serves an important purpose and I should, I suppose, commend the **Journal** for deciding to publish it, except that, in my judgment, what is good could have been better if I had an opportunity to read a proof and to have made some additional comments to bridge a gap between then and now.

Finally, the fundamentals are there, but not the cohesiveness I would like.

Written in good faith, I am

SAMUEL MORRISON, MD

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APR. 23-25, 1980
BALTIMORE CONVENTION CENTER, BALTIMORE, MD
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SCIENTIFIC EXHIBIT APPLICATION

Scientific exhibits are an integral part of the Annual Meeting. All physicians, medical institutions, and organizations having an appropriate exhibit are urged to complete the application below for consideration by the Exhibit Subcommittee.

PLEASE INDICATE THE CATEGORY OF EXHIBIT:

- ☐ **SCIENTIFIC EXHIBIT:** Result of original scientific research which involved the personal contribution of the exhibitor. Its purpose is to advance medical knowledge. It should not be designed for the personal, financial gain of the exhibitor.
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- ☐ **CLINICAL DISPLAY EXHIBIT:** Must be of a scientific nature, but not necessarily original research. The exhibitor need not be personally involved in the research. The exhibit should contribute to the advancement of knowledge of other members of the profession, but it may also contribute to the personal, financial gain of the exhibitor.
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EXHIBIT FEE: \$60 for each 8' by 10' space.

PLEASE COMPLETE AND SUBMIT BY JAN. 31, 1980

Chairman, Subcommittee on Exhibits
Med-Chi
1211 Cathedral St.
Baltimore, MD 21201

DATE SUBMITTED

TITLE OF EXHIBIT

NAME AND PROFESSIONAL TITLE OF EXHIBITOR

EXHIBITOR'S ADDRESS TELEPHONE

STATE CITY ZIP

INSTITUTION PARTICIPATING IN EXHIBIT

AMOUNT OF SPACE REQUIRED WIDTH DEPTH HEIGHT

ANY SPECIAL REQUIREMENTS NOT COVERED IN THIS FORM

HAS EXHIBIT BEEN SHOWN AT OTHER MEDICAL MEETINGS?

PLEASE ATTACH A 50-WORD DESCRIPTION OF EXHIBIT.

RULES GOVERNING SCIENTIFIC EXHIBITS

1. U-Neek Display is the official decorator for the 1980 meeting, and, upon request, will transport, set up and dismantle an exhibit.
2. If the exhibitor elects to transport, and/or set up and dismantle his/her own exhibit, he/she is then fully responsible for his/her own exhibit.
3. The exhibitor is fully responsible for the content, arrangement and presentation of exhibit.
4. The Medical and Chirurgical Faculty will provide an 8' x 10' booth, backdrop and siderails, one covered table and two chairs.
5. ALL ELECTRICAL OUTLETS will be billed directly to exhibitor from the Convention Center and should be ordered through U-Neek Display.
6. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS.
7. No reference to, or credit for, financial aid shall be shown on exhibit.
8. Only generic names may be used. No trade names are permissible.
9. Each exhibit should be manned at all times by someone familiar with its content.
10. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.
11. Inquiries should be directed to:
Ms. Mary E. Galeckas at Med-Chi, (301) 539-0872.

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Committee on Alcoholism
Maryland-DC Society of Rehabilitation Medicine
Maryland Orthopedic Society
John Staige Davis Society of Plastic Surgeons of Maryland
Maryland Radiological Society
Maryland Society of Allergy
Maryland Ophthalmological Society/Maryland Academy of Ophthalmology
Maryland Dermatological Society
Public Relations Committee
Committee on Physician Rehabilitation
Occupational Health Committee
Maryland Psychiatric Society
Maryland Society of Gastrointestinal Endoscopy
Maryland Society of Cardiology
American Heart Association, Central Maryland Chapter, Stroke Subcommittee
Maryland-DC Society of Anesthesiology
Maryland Urological Society

•

The above program is subject to change. Watch for further details in upcoming issues of the **Journal**.

Business Sessions

Lunch and Learn

MMPAC's Bash-on-the-Bay

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WILLIAM A. PILLSBURY, MD, President

EMIDIO A. BIANCO, MD, Chairman

Committee on Program and Arrangements

Transactions

Report of Maryland Delegates to the AMA House of Delegates, July 22-26, 1979, Chicago, IL

The Maryland delegation to the AMA Annual House of Delegates Meeting, consisting of the Faculty's two Delegates, three Alternate Delegates, the President and President-Elect, as well as staff, attended the annual session in Chicago from July 22-26, 1979.

The AMA House considered 262 resolutions and reports. Stephen K. Padussis, MD, served on Reference Committee F, and each of the other attendees was assigned to a specific Reference Committee to hear the general discussion that takes place on each resolution or report.

As is customary during this session, the delegation caucussed with the Southeastern Coalition States to interview candidates for various offices in the AMA. In addition, the delegation also caucussed by itself to consider the various items before the House.

It would be impossible to provide a complete run-down on each issue discussed by the Committees and the reports made to the House itself. The more important issues to come before it and the action taken is as follows:

Liaison Committee on Continuing Medical Education—The AMA House approved a recommendation of the Council on Medical Education which recommended the withdrawal of AMA from LCCME and the prompt resumption of AMA's previous responsibility for the voluntary accreditation of CME through the establishment of a Committee on Accreditation of CME of the AMA. This will probably entail the disbanding of the LCCME, whose staff and facilities were provided by AMA. AMA has resumed the responsibility for accreditation of CME which it held prior to 1977. Institutions already accredited for CME will continue to be recognized as such by AMA.

Changes in the Principles of Medical Ethics—The House approved a progress report of the Ad Hoc Committee on the Principles of Medical Ethics and avoided a possible confrontation with the Federal Trade Commission. The FTC has said that no changes in the Principles can be made unless previously approved by the FTC. Further action on any changes in the Principles will be considered by the House of Delegates in December, 1979. The Principles were first adopted in 1847 and have been revised only twice since.

Chiropractic—The House abandoned its blanket condemnation of chiropractic as an "unscientific cult," but said "The AMA knows of no scientific evidence to support manipulation and adjustment as appropriate treatment for human ailments such as essential hypertension, heart disease, stroke, cancer, diabetes and infections." Under the new policy, the AMA would continue to warn the public of the hazards of relying on spinal manipulation to treat such conditions. While the AMA's 1966 policy on chiropractic warned that voluntary association with cultists is unethical, the new policy statement asserts that a physician may refer a patient to a "Licensed limited practitioner whenever he believes that this will benefit the patient."

National Health Insurance—The controversy over NHI which has persisted for over 30 years continues. The House reaffirmed an action taken by the House last December that AMA would introduce a health insurance bill into Congress "only if necessary" and if introduced, to include the following four principles:

1. "Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance.

2. "A simple system of uniform benefits provided by the Federal, State and local governments for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.

3. "A nationwide program by the private insurance industry of America (and government, if necessary, for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.

4. "A program developed pursuant to those principles should be administered at the State level with national standardization through Federal guidelines."

Other House Actions—The House endorsed the concept that AMA should strive to become the umbrella organization for all physician organizations. At the same time, it called on AMA's Long-Range Planning and Development Council and the state medical societies to study the concept of changing AMA from an association of individual members to an organization of American medical organizations. In addition, the House authorized the Board to conduct pilot studies in the area of recruiting AMA members directly who may or may not be members of county and state medical societies.

In the areas of Health Planning and HMOs, various actions were taken. In connection with planning, the AMA was urged, "... To work for an increased role in health planning for the medical society and physicians at the local level, and a diminished role for Federal legislative and bureaucratic bodies."

The AMA House adopted a motion that, "... condemn(s) the Department of Health, Education and Welfare for the use of public funds to promote enrollment of Medicare beneficiaries in HMOs over other forms of health care delivery."

Other individual actions taken by the House covered a variety of subjects.

These included:

Physician Extender Programs: Report F of Council on Medical Service **Adopted** with the following clarification, and the Council on Medical Service requested to continue to study and reevaluate its position on physician extender programs:

It shall be AMA policy that the personal presence or participation by the supervising physician in the physician extenders activities where the services are rendered should be the standard of care in the usual practice settings. In unusual practice settings, exceptions to this standard of care should be determined and a specific waiver to this standard may be granted by the state medical board on an individual case-by-case basis.

Payments by insurance carriers for reconstructive surgery of the breast: Resolved, That the AMA adopt the policy that reconstruction of the breast for rehabilitation of the post-mastectomy cancer patient should be considered reconstructive surgery rather than esthetic surgery.

Physician's Role in returning patients to their jobs: Resolved, That the AMA encourage physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety.

Opposition to reduction in Medicare fees to private and non-salaried physicians whose patients are in teaching hospitals: Report I of the Board of Trustees informed the House of Delegates of AMA efforts opposing reductions in Medicare payments to private and non-salaried physicians whose patients are in teaching hospitals, and recommended adoption of the report in lieu of Resolution 76 (I-78).

Energy policy of the Federal Government with respect to Physicians: Report SS of the Board of Trustees informed the House of the Association's activities regarding proposed gasoline regulation, indicated that the Association will continue to monitor the situation and to work with government and private agencies in this matter, and recommended that the report be adopted in lieu of Resolution 7 (I-78).

Continuing Medical Education:

Resolved, That the AMA deplores excessive charges for CME programs which exploit physicians or distort the real purposes of education programs, and be it further

Resolved, That the AMA encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges, and be it further

Resolved, That the AMA make a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost.

Resolved, That the AMA study the current status of CME in the US, the effectiveness of mandatory CME legislation in assuring professional competence, and comparative charges by organizations conducting CME programs and report to the House of Delegates at the 1980 Annual Meeting.

Medical School Curriculum:

Resolved, That the AMA adopt and help implement the principle that all American medical schools include in the curriculum appropriate instruction in medical economics, designed as preparation for the practice of health care delivery including cost containment, and an understanding of the functions of organized medicine in safeguarding the interests of patients and discharging the obligations of the medical profession and be it further

Resolved, That the AMA adopt and help expedite

the principle that appropriate instruction in medical economics be included in graduate training and continuing medical education programs.

State Medical Licensure Laws:

Resolved, That the AMA is opposed to medical licensing laws that define medical specialty practice and limit a physician's practice by specialty, and that this action be communicated to state medical societies.

Physician well-being:

Resolution 168 asked that the AMA develop and implement a plan to utilize its resources to prevent impairment and promote physician well-being throughout the continuum of medical education and to report to the House at the 1979 Interim Meeting and periodically thereafter as appropriate.

Resolution 168 ADOPTED

FTC Interference:

Resolved, That the AMA seek legislation which would permit constituent medical societies of the AMA to review the reasonableness of physicians' charges to protect the public, and be it further

Resolved, That the AMA seek legislation if necessary to protect the role of the constituent and component medical societies in the discipline of members who charge excessive fees or exploit their patients.

Complete details on any subject may be obtained through the Faculty Office, including copies of any reports considered by the House.

RUSSELL S. FISHER, MD, Chairman, Maryland Delegation
CHARLES F. O'DONNELL, MD, Towson
STEPHEN K. PADUSSIS, MD, Baltimore

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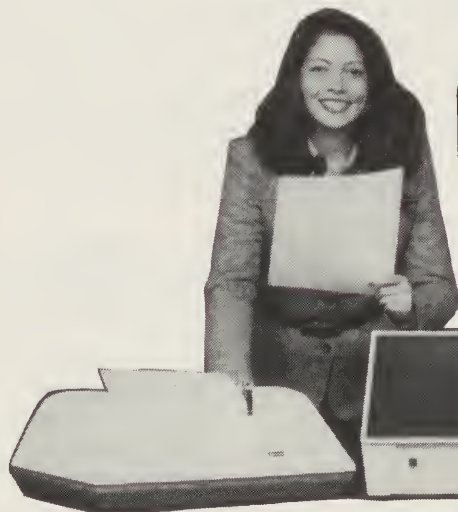
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Executive Director's Newsletter

December, 1979

NEWS Russell S. Fisher, MD, Baltimore, has been named "Pathologist of the Year" by the College of American Pathologists. OF Recently designated Fellows of the American College of Surgeons are Drs. Juan M. Pardo, Arnold; Douglas A. Finnegan, Annapolis; NOTE and Myron I. Murdock, Bowie. Tillman D. Johnson, MD, of Elkton, was honored at a recent dinner occasioning his retirement to Punta Gorda, Fla. Many dignitaries attended the event where he was presented with a certificate of recognition from Governor Harry R. Hughes.

GOLF, The Pennsylvania Medical Society is sponsoring three Scientific/Vacation programs in the near future. Skiing and TENNIS, Scientific programs are combined for a week at Snowmass, Colorado, February 17-24; Golf/Tennis are planned for a week SKIING, February 25-March 5 at Orlando, Florida; and strictly a vacation program is set for March 19-26 in Kauai, Hawaii. ANYONE? Details can be obtained from Ms. Mary Galeckas at the Faculty office.

"BOAT PEOPLE" Concern has been expressed over the plight of the "boat people" REFUGEES refugees by the AMA House of Delegates, and the AMA Board has been instructed to develop a program to respond to the medical emergencies of these people.

Physicians who may wish to volunteer their services for this cause should contact the Office of International Medicine at AMA Headquarters in Chicago. Only limited numbers of volunteer physicians are being placed for short-term stays of three months.

In addition, the Center for Disease Control has requested assistance from volunteers to provide immediate relief to Indochinese refugees who may be ill when they arrive at ports of entry—Washington, DC is one port of entry. Physician volunteers might be called upon once every three or four months.

Contact the Faculty office if you are interested in volunteering in this latter category.

NEW In response to increasing inquiries regarding ownership, BOOKLET availability, and rights to review patient medical records, the Faculty has prepared a booklet outlining current legal and ethical requirements in this regard.

Copies may be obtained by contacting the Faculty office, 301-539-0872.

ENERGY

While it is not anticipated that gasoline supplies will be in short supply in the near future, the Faculty still has in effect its arrangement with the Energy Office for special allocation of gasoline for use by physicians.

NEEDS

Storage facilities and adequate control, so that it is used by physicians only and for medical services, must be worked out by component medical societies.

Should shortages develop, this system can be implemented promptly to alleviate such problems. Some medical societies have been obtaining release of supplies from the emergency allotment for this purpose each month, even though a shortage does not exist at this time.

MEMBERSHIP

We are again preparing to randomly survey 20% of our membership to determine your feelings on our work and the benefits offered to you, the members. We cannot urge you strongly enough to complete and return the survey questionnaire, so we can be more responsive to your needs.

SURVEY

RESOLUTIONS

Deadline date for receipt of resolutions for consideration at the 1980 annual House of Delegates session is

DEADLINE

FRIDAY, FEBRUARY 29, 1980.

Receipt in the Faculty office must be by close of business on that date.

All resolutions must be sponsored by a member or component society of the Faculty, the Council or committees of the Faculty, provided, however, that a resolution introduced by an individual member must have the endorsement of either one-third of the membership of his component society or 30 members of his component society, whichever is smaller.


Executive Director

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JOHN SARGEANT, CAE, Executive Director

House of Delegates

The House of Delegates met in Semiannual session on Sept. 29, 1979 and took the following actions:

1. Approved the meetings of House sessions on May 2 and 5, 1979.
2. Adopted the Auditor's Statement for the 1979 calendar year.
3. Received various Committee Reports on which members were given an opportunity to ask questions or comment.
4. Adopted Memorial Resolutions for A. Austin Pearre, MD, Frederick; Lila H. Youngquist, Montgomery County and Paul V. Joliet, MD, Hagerstown.
5. Adopted a Congratulatory resolution to J. Roy Guyther, MD, of Mechanicsville, on the occasion of his selection as Family Physician of the Year and his recognition by President Jimmy Carter.
6. Elected various members to the Board of the Maryland Foundation for Health Care.
7. Recommended a bylaws amendment dealing with a change in the manner of establishing dues.
8. Adopted a bylaw amendment dealing with a requirement that members of the Legislative Committee be full voting members of the Faculty.
9. Adopted the following resolution as recommended by the Liaison Committee with the Department of Health and Mental Hygiene:

Resolution 1S/79

Adopted without dissent, Sept. 29, 1979

Discrepancy in Medicaid Fee Payments between those paid to Physicians and those paid for identical services rendered in hospital settings

WHEREAS, When the Federal Government enacted the Medicaid and Medicare law, it was predicated on the principle that all citizens would be treated alike and that physicians and others would be paid as they were for private patients and

WHEREAS, There is currently a major differential between what is paid a physician under the State Medicaid program as compared to that paid hospitals for identical services rendered in these institutions and (Note 1)

WHEREAS, Despite attempts by the Liaison Committee of the Medical and Chirurgical Faculty to correct this discrepancy, no progress has been made and

WHEREAS, This major differential is discrimina-

tory and has caused many physicians to discontinue adding new Medicaid patients to their practices, and has, possibly, influenced some physicians to discontinue seeing Medicaid patients and

WHEREAS, Various public interest groups and governmental agencies have recognized this discrepancy and urged its correction and (Note 2)

WHEREAS, Inappropriate use of hospital facilities by Medicaid patients increases unnecessarily the cost of health services under the Medicaid program and has increased rapidly the total cost of "hospital" payments in the Medicaid budget for the Department of Health and Mental Hygiene and

WHEREAS, Medicaid patients should receive continuity of care from a personal physician, something difficult, if not impossible, for them to receive under the present system and

WHEREAS, the usual, customary and reasonable payment basis for Medicaid services rendered provides the most appropriate levels of reimbursement to physicians, recognizes differences in charging patterns that validly exist and encourages physicians to see such patients, therefore, be it

Resolved, That the Medical and Chirurgical Faculty goes on record as supporting, in principle, any Department of Health and Mental Hygiene proposal to reallocate Medical Assistance Program funds so as to increase physician reimbursement to the usual, customary and reasonable rate of private physicians so the system will be competitive and result in total reimbursement not exceeding the total budgeted dollars.

NOTE 1: Physician office visit fee paid, as of July 1, 1979, was \$9 per visit; (\$6.98 for FY 1978) Hospital visit fee paid ranges from \$25 to \$67, average is \$46.62, FY 1978.

NOTE 2: Health Services Cost Review Commission
Maryland Health Planning and Development Agency
Central Maryland Health Systems Agency
Southern Maryland Health Systems Agency
Montgomery County Health Systems Agency
Maryland Conference for Social Concern

10. Endorsed unanimously, the candidacy of Russell S. Fisher, MD, Baltimore, for a seat on the AMA Board of Trustees.

Executive Committee

The Executive Committee met on Oct. 11, 1979 and took the following actions:

1. Designated Donald M. Spangler, MD, Baltimore, to serve on a Blue Cross Physicians Review Panel as a replacement for a physician who has retired from active practice.

2. Deferred action on a request for financial assistance from a physician's widow.

3. Endorsed the principle of a proposed study by the Maryland Institute for Public Health Research that would deal with identification at an early stage of traits that lead to impaired physicians.

4. Increased the per diem for the Maryland Delegation to the AMA House of Delegates sessions from \$35 to \$55.

5. Referred to the Committee on Drugs a question raised by the Commission on Medical Discipline on the unauthorized dispensing of drugs by physicians and in "public clinics."

6. Approved expending \$1,300 from the Educational Fund for the purpose of continuing the series presented by WBJC-FM radio on health issues.

7. Referred to the Policy and Planning Commission a suggestion the Faculty provide non-voting membership for Physician Assistants, or a Faculty "section" involving this category of health personnel.

8. Approved introduction of legislation dealing with wrongful use of civil proceedings.

9. Authorized legal counsel to speak on an informal basis with the Workmen's Compensation Commission to clarify with insurance carriers the "Guide" published by the Commission.

10. Established a Task Force to review present policy and recommend any changes in providing legal defense for members of Faculty and Component Society committee members.

11. Authorized the Economics Committee to poll all state societies to ascertain the range of financial fringe benefits offered their members.

12. Established a new format for the meeting of Component Society Presidents and Secretaries and Statewide Specialty Society Presidents and Secretaries, and set Wednesday, March 26, 1980 as the date for this meeting.

13. Authorized recommendation of a physician for appointment to the Medical Advisory Board, Motor Vehicle Administration.

14. Approved exploration of the potential involved in reviewing costs of compliance by physicians with various governmental laws and regulations.

15. Authorized the President to designate a nominee to serve on the Advisory Board of Hospital Construction.

16. Approved support of the candidacy of John M. Dennis, MD, Dean of the University of Maryland School of Medicine, for the post of Chancellor, University of Maryland Baltimore City Campus.

17. Designated a Task Force to review proposals being offered for assessment of quality of care for inpatients.

18. Approved a revised wage and salary policy. □

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Sen. McGuirk Speaks

BCMS sessions with leading legislators resumed in July, 1979. **Ian R. Anderson, MD**, Chairman of the Legislative Committee, arranged the meeting of Directors and Committee Members with State Senator Harry McGuirk. With our lobbyist, Richard Rombro, present, it was like a reunion. Sen. McGuirk, with a little prodding, reviewed the sources of many anti-physician sentiments in the Legislature. He told again some of the intricacies of our State legislative process and explained how bringing pressure to bear in the wrong place, committee or department never gets anywhere. It might be "McGuirk's Law:" You have to know who's in charge before you can start." It was mentioned that action against physicians hurts the patients.

Directors Meet

The Directors met in August. **Roland T. Smoot, MD**, Chairman of the Policy and Planning Committee, announced that component societies are now expected to appoint their representatives to Med-Chi's three committees: Legislative, Health Planning and Policy and Planning. So far, BCMS has had no policy on the naming of such representation. Dr. Smoot proposed interlocking BCMS and Med-Chi choices. For the Legislative and Health Care Committees, the Chairman of the BCMS Committee should be our representative to the Med-Chi counterpart. If unable to serve, a Vice Chairman can be named. The Med-Chi Policy and Planning Committee involves a three-year term, however. It seemed feasible that our Policy and Planning Committee should name a suitable member who would be appointed by the Directors for the three years.

Bylaws

Agreeing with the Bylaws Committee recommendation given by Chairman **William J. McClafferty, MD**, the Directors voted, in our own elections, that a plurality was preferable to requiring a majority. Our Bylaws need not be changed for this purpose.

Members Nominated

Our Directors responded to a request by **Bernard S. Karpers, Jr., MD**, Med-Chi Secretary, for nominees to the Maryland Foundation for Medical Care. Renomination of our present representatives, whose terms end this year: **Timothy D. Baker, MD**; **Edward J. Kowalewski, MD** and **Nicholas J. Fortuin, MD** will be forwarded.

1980 Physical Fitness Fair

Vincent Fitzpatrick, MD, reported progress of the Physical Fitness Fair for next Spring. The Fair's theme will be "It's fun to be healthy!" Dates are April 12-13 at

the Baltimore Convention Center. Robert Mancke of the BCHD is Chairman of the Board planning the Fair. Incorporation papers are being drawn up and, if approved by our legal counsel, will be signed by BCMS's representative on the Committee. General responses from possible participants have been good, but financial support is not completely firm as yet. Although initiated as a health fair for women, any gender discrimination has disappeared.

A New Annual Meeting...

Something new in BCMS Annual Meetings is coming. Sentiment to both have our meetings in our own city, as well as for a change in format, combined to bring it about. It's timely, too, since this is BCMS's own 175th anniversary as a Society and 75th as a component of Med-Chi.

So, on Thursday, Dec. 6, 1979 at 6:30 PM, we will meet at Center Stage, 700 N. Calvert St., for our Annual Business Meeting and refreshments, to be followed by a stage show of **A Christmas Carol: Scrooge and Marley** as adapted by Israel Horovitz and interpreted by the Center Stage cast. It will be a good idea to get reservations in early. Parking will be ample.

General Meeting

Our regular General Meeting in September, 1979, was sponsored by our Auxiliary, who were present in charming numbers. Routine business was promptly handled by President **Albert M. Antlitz, MD**. **William J. McClafferty, MD**, Chairman of the Bylaws Committee, gave a first reading of the many changes in our Bylaws made necessary by recent changes in our meetings schedule, dues structure and membership requirement. These will be printed and sent to members prior to the vote at the next meeting.

The scientific part of the meeting was **Challenges in the Management of Breast Cancer: Surgical, Radiotherapeutic and Medical Aspects**.

R. Robinson Baker, MD, Surgeon-in-charge at the Oncology Center of Johns Hopkins Hospital, began with a comparison of screening methods. Physical examination, mammography and thermography are decreasingly effective—in that order. Clinical management, though becoming more versatile, lacks long-term controls. Noting that, prior to 1970, radical surgery was done at Hopkins with very few excision-biopsy for controls, he said that since 1971, the reverse is true. Without controls, long-term statistics have little value. Management ranges from biopsy-excision, pre-treatment excision and the use of isotope scans. Seven variations on management were statistically compared as to outcome, both pro and retrospectively.

Martin D. Abeloff, MD, Director of the Johns Hopkins Oncology Center, spoke on the importance of preventing recurrences and non-surgical methods to achieve it. Prognosis of recurrence is related to the presence of neoplastic cells in the lymph glands. They have found survival is better if less than four are involved. He reviewed the three major prongs of attack: 1) cytotoxic, chemotherapeutic; 2) endocrine, additive or ablative; 3) immunosuppressive. Each has its own risks and its own statistical probability of cure. Dr. Abeloff called attention to the European countries that

reported improved results with combined chemotherapy long before the United States did—while we were still involved in single-mode chemotherapy. He attributed this superiority in research to the absence of rules of informed consent in those nations.

Stanley E. Order, MD, Director of Radiation Oncology at Johns Hopkins Hospital, emphasized the need to consider the whole patient, in particular the psychologic impact of having cancer. Dr. Order considered the seven primary treatment schedules further, from 'lumpectomy' without or with radiotherapy pre- or post-operation. The significance of inner and outer quadrant lesions with respect to metastases is different and important. Reserving radiotherapy to treat recurrences had its advocates also.

Dr. Order stressed repeatedly that there are many options in therapy selection and insisted that the patient should have his/her say about it. He found statistics nowhere so firm that unacceptability to the patient can be justified. He showed slides of the improvements in reconstruction surgery available today, even to aureolar transplantation. Anti-estrogen compounds, although dependent on the presence of steroid receptors for effectiveness, do offer improved, i.e., with less side effects, therapeutic pathways to success. With regard to metastases, he said, prevent or treat early. □

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Auxiliary

MRS. ALBERT J. STRAUSS, JR.
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MRS. R. KENNEDY SKIPTON
Editor

Christmas Sherry and Auction for Anne Arundel County Auxiliary

The Auxiliary to the Anne Arundel County Medical Society is planning its fifth Christmas Sherry and Auction. This has become one of our most successful annual events.

The Sherry is held at the home of one of our members. It is beautifully decorated for the Holiday Season, which adds to the festivities. Each member brings a gaily-wrapped gift for the Auction. To help the auctioneer, a note is placed on each gift suggesting a suitable value for the package.

After a social hour and light lunch, the Auction begins. It doesn't take long for everyone to get into the spirit of the occasion, and we soon reach our objective: funds to help the less fortunate to enjoy Christmas.

The first year, the proceeds were used to help two Vietnamese families. The St. Vincent de Paul Society received the money for the next two years. Members of the St. Vincent de Paul Society dispense the money on the basis of need.

Last year, we 'adopted' five families in the country through the Department of Social Services. The Social

Worker gave us the first names, ages and sizes of the children of the families. There were a total of 17 children. In addition to the gift for the Auction, our members brought used clothing and staple food items.

The money from the Auction was used to purchase more food, which included canned hams, fresh fruits and vegetables, canned goods and toilet articles. Along with the food and clothing, each family received a gift certificate for a local shoe store. The remainder of the \$925 proceeds was given to the St. Vincent de Paul Society.

Committee members did the shopping and sorting for the various families. This made the busy Christmas-time even more hectic; however, each agreed that her Christmas was more memorable knowing that five other mothers were able to give their children "A Very Merry Christmas."

MRS. DANIEL C. MCCABE

President — Auxiliary
to the Anne Arundel Medical Society

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Discipline Commission Action

Editor's Note: On instruction of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order" will be published in the JOURNAL.

IN THE MATTER OF RICHARD TYSON, MD BEFORE THE
COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention pursuant to the provisions of Article 43, §130 of the Annotated Code of Maryland, the Baltimore City Medical Society conducted an investigation of Richard Tyson, MD (the "Respondent"). Thereafter, the Commission on Medical Discipline of Maryland (the "Commission") after considering the report and recommendations submitted, determined to charge the Respondent with violation of the following subsection of Article 43, §130(h):

(4) the physician has been charged with a crime involving moral turpitude, and has entered a nolo contendere or guilty plea or has been convicted of a crime.

Appropriate notice of the charge and the ground from which it arose was given to the Respondent and hearing on said charge was held on Aug. 21, 1979. The following members of the Commission were present at the hearing: John E. Adams, MD; Albert M. Antlitz, MD; Jerome J. Coller, MD; Arthur T. Keefe, MD; Eli M. Lippman, MD; William Pillsbury, Jr., MD and Frank M. Shipley, MD. John E. Adams, MD presided as Chairman of the Commission. Also present were Jack C. Tranter, Assistant Attorney General, to advise the Commission as to rules of evidence and Susan K. Gauvey, Assistant Attorney General to present the case on behalf of the Commission. The Respondent appeared with George L. Russell, Jr., Esquire, his counsel.

Following introductions, Ms. Gauvey presented the Commission's case, which consisted of the following documentary evidence:

State's Exhibit #1—Certified copy of the indictment in **US of America v. Richard F. Tyson**, US District Court for the District of Maryland, Criminal No. H-77-015.

State's Exhibit #2—Certified copy of the judgment and probation/commitment order in **United States of America v. Richard F. Tyson**, US District Court for the District of Maryland, Criminal No. H-77-015.

State's Exhibit #3—Certified copy of various proceedings before the Honorable Alexander Harvey II.

Following introduction of this evidence, Ms. Gauvey rested her case.

Mr. Russell then presented the case on behalf of the Respondent. The following documentary evidence was produced:

Respondent's Exhibit #1(a)—Copy of a memorandum dated May 14, 1979 and attachments from Francis W. Lanasa, US Probation Officer, to the Honorable Alexander Harvey II, US District Judge.

Respondent's Exhibit #1(b)—Copy of a certificate of the American Academy of Family Physicians.

Respondent's Exhibit #1(c)—Copy of a certificate of the University of Maryland School of Medicine Family Practice Program.

Respondent's Exhibit #1(d)—Copy of a letter dated July 10, 1979 from C. Earl Hill, MD to the Respondent.

Respondent's Exhibit #1(e)—Copy of a letter dated October 11, 1977 from Stephen D. Wilson to the Respondent.

Respondent's Exhibit #1(f)—Copy of a letter dated March 10, 1977 from Elliott R. Fishel, MD, Chairman, Peer Review Committee, Baltimore City Medical Society to the Respondent.

Respondent's Exhibit #1(g)—Copy of the American Medical Association's Physician's Recognition Award issued to the Respondent.

Respondent's Exhibit #1(h)—Copy of a certificate of the American Academy of General Practice issued to the Respondent.

Respondent's Exhibit #1(i)—Copy of a letter dated Dec. 10, 1973 from the American Board of Family Practice to the Respondent indicating that he is a diplomate of that board.

After testimony was heard from the Respondent and closing arguments were made by both Ms. Gauvey and Mr. Russell, the hearing was concluded.

Findings of Fact

The Commission finds:

1. That the Respondent pled guilty to one count of 18 USC Sections 1341 and 2, mail fraud, aiding and abetting.
2. That the Respondent was sentenced to a fine of \$1,000 and was placed on probation for a period of three years.
3. That the Respondent is Board certified in his speciality and appears to be a competent practitioner.

Conclusions of Law

From the foregoing Findings of Fact, the Commission concludes that the Respondent has been charged with a crime involving moral turpitude, 18 USC Sections 1341 and 2, mail fraud, aiding and abetting, and has been convicted of one count of such crime. Accordingly, the Commission by an unanimous vote adjudicates the Respondent GUILTY of violating Article 43, Section 130(h)(4) of the Annotated Code of Maryland.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 4th day of September, 1979 by the unanimous vote of those members of the Commission hearing this case

ORDERED that the license to practice medicine and surgery in the State of Maryland heretofore issued to the Respondent Richard F. Tyson, MD by the Board of Medical Examiners of the State of Maryland is REVOKED, and be it further

ORDERED that the foregoing revocation shall be effective three months after the date of this Order, and be it further

ORDERED that six months after the effective date of the foregoing revocation such action shall be STAYED with the Respondent placed on PROBATION for two and a half years subject to the following conditions:

1. That the Respondent shall submit to a quarterly review of his practice by the Peer Review Committee of the state medical society or any other body or individual designated by the Commission.

2. That the Respondent shall not engage in activities of the type that led to his criminal conviction.

3. That the Respondent's practice of medicine shall be in accordance with those standards expected from a competent practitioner of medicine in Maryland.

4. That the Respondent shall not treat any person who is referred to him by an attorney as a result of injuries received in an automobile accident and be it further

ORDERED that if the Respondent violates any of the foregoing conditions of probation, or if the Peer Review Committee submits a report that he is not practicing competently, the Commission may, after notification and a hearing, withdraw the stay of the revocation of his medical license or impose any other disciplinary sanction that deems appropriate, and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with the Annotated Code of Maryland, Article 43, §130(m).

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

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Findings of Fact, Conclusions of Law and Order

Upon certain information coming to its attention pursuant to Article 43, §130 of the Maryland Code, the Peer Review Committees of the Medical and Chirurgical Faculty (the "Med-Chi") and the Prince George's County Medical Society conducted investigations into the medical practice of Magin T. Quiambao, MD (the "Respondent"). Thereafter, the Commission on Medical Discipline (the "Commission") determined to charge Respondent with certain violations of the Code. The violations charged involved the following subsection of Article 43, §130(h):

(18) Professional incompetence.

Appropriate notice of the charge and the grounds from which it arose was given to the Respondent and a hearing on said charge was held before the Commission on Aug. 1, 1978. The hearing convened at 2 PM before the entire Commission. The Respondent appeared represented by Henry R. Lord, Esquire. Stephen J. Sfekas, Assistant Attorney General, presented the case on behalf of the Commission. Jack C. Tranter, Assistant Attorney General, advised the Commission on rules of evidence.

Pursuant to an agreement of counsel and with the concurrence of the Commission, the case was presented out of normal order to accommodate several witnesses. David M. Goldman, MD was first called by Mr. Sfekas as a witness for the Commission. His testimony was followed by that of J. Andrew Armer, MD, who testified on behalf of the Respondent. Following this testimony, opening statements were made by Messrs. Sfekas and Lord. As part of his statement, Mr. Lord made and filed two Motions to Dismiss, or in the Alternative to Disqualify, which motions were denied by the Commission. Mr. Sfekas then continued with the presentation on behalf of the Commission. Testimony was heard from Joseph I. Berman, MD; however, after the completion of Dr. Berman's testimony, because the court reporter was unable to continue, it was necessary to continue the hearing. The following documentary evidence was admitted into evidence at this session.

State's Exhibit #1—Copy of a letter dated February 10, 1978, from David M. Goldman, MD to Joseph I. Berman, MD.

State's Exhibit #2—Curriculum Vitae for Magin T. Quiambao, MD.

State's Exhibit #3—Report on an office visit to Dr. Magin T. Quiambao.

State's Exhibit #4—Curriculum Vitae for Joseph I. Berman, MD.

State's Exhibit #5—Copy of a letter dated Apr. 20, 1978, from Magin T. Quiambao, MD to Joseph I. Berman, MD.

State's Exhibit #6—Copy of a letter dated March 27, 1978, from Leopold Weindelmayer addressed to "To whom it may concern."

Respondent's Exhibit #1—Copy of a letter dated September 13, 1977, to the Peer Review Committee from Robert Ruderman, MD.

Respondent's Exhibit #2—Curriculum Vitae for John Andrew Armer, MD.

Respondent's Exhibit #3—Patient record form used by Respondent.

Respondent's Exhibit #4—Copy of a letter dated June 1, 1978, from J. Andrew Armer, MD to Henry R. Lord, Attorney.

Respondent's Exhibit #5—Copy of a letter dated May 23, 1977, from Joseph I. Berman, MD to Perry Hookman, MD.

Respondent's Exhibit #6—Copy of a letter dated September 22, 1977, from David M. Goldman, MD to Joseph I. Berman, MD.

Respondent's Exhibit #7—Copy of a letter dated June 17, 1977 from Joseph I. Berman, MD to Magin T. Quiambao, MD.

The hearing was reconvened on Sept. 5, 1978 before the entire Commission. The Respondent was present represented by Henry R. Lord, Esquire. Mr. Sfekas presented the case on behalf of the Respondent; Mr. Tranter advised the Commission on rules of evidence. The hearing began with the recall of Joseph I. Berman, MD by Mr. Lord. After the completion of Dr. Berman's testimony and the introduction of the following documentary evidence by Mr. Lord, Mr. Sfekas concluded his case.

Respondent's Exhibit #8(a)-(e)—Copies of the annual reports of the Peer Review Committee of Med-Chi for the years 1974-78.

Respondent's Exhibit #9(a)—Copy of a listing of the current members of the Peer Review Committee of Med-Chi.

Respondent's Exhibit #9(b)—Copy of undated correspondence to the members of Council of Med-Chi from Bernard S. Karpers, MD, Secretary.

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Respondent's Exhibit #9(c)—Listing of the officers and Committee Memberships of Med-Chi, Apr. 22, 1977 through the Annual Meeting, 1978.

Respondent's Exhibit #10(a)—Copy of an article written by Joseph I. Berman, MD appearing in the February, 1976 **Maryland State Medical Journal**.

Respondent's Exhibit #10(b)—Pamphlet entitled **A Plan for the Reeducation of the Physician in Need**.

Respondent's Exhibit #10(c)—Guidelines used in Reviewing Physician's Office Practice approved by the Med-Chi Council Jan. 19, 1978.

Respondent's Exhibit #11(a)—Copy of a letter dated March 7, 1978 from Joseph I. Berman, MD to the Commission.

Respondent's Exhibit #11(b)—Copy of a letter dated May 8, 1978 from Joseph I. Berman, MD to John E. Adams, MD.

Respondent's Exhibit #12—Curriculum Vitae for Sidney B. Seidman, MD.

Respondent's Exhibit #13(a)—Copy of a memo dated Aug. 22, 1978 from Mrs. Constance Townsend to Dr. Berman.

Respondent's Exhibit #13(b)—Copy of a letter dated Aug. 22, 1978 from Mrs. Constance Townsend to John E. Adams, MD.

Respondent's Exhibit #14(a)-(m)—Copies and originals of various correspondence of the Peer Review Committee of the Prince George's County Medical Society regarding Respondent.

Mr. Lord then moved for a dismissal of certain grounds upon which the charge of professional incompetence had been made against Respondent as set forth in the charge letter dated May 4, 1978. This motion was denied.

Mr. Lord then presented the balance of the case on behalf of the Respondent. Testimony was heard from the Respondent and Salah H. Hosny, MD. The following documentary evidence was also produced.

Respondent's Exhibit #15—Floor plan of the Respondent's office.

Respondent's Exhibit #16(a)-(s)—Various photographs of the Respondent's office.

Respondent's Exhibit #17—Affidavit dated July 31, 1978 from Louis J. Meyer, RPh.

Respondent's Exhibit #18(a) and (b)—Photographs of specimen bottles.

Respondent's Exhibit #19—Copy of the list of contraindications for the Magnatherm.

Respondent's Exhibit #20—Curriculum Vitae for Salah H. Hosny, MD.

Following closing arguments by Messrs. Sfekas and Lord, the hearing was concluded.

Findings of Fact

The Commission finds:

1. That the evidence presented regarding inadequate medical records and X-rays is not sufficient to sustain those allegations.

2. That at the time of the investigation of his practice, Respondent kept tissue he removed during office surgery in unlabelled bottles in which numerous pathological specimens were mixed.

3. That the retention of specimens in this fashion makes it absolutely impossible to identify specific specimens.

4. That following the date of the investigation of his practice and prior to the conclusion of the hearing, the Respondent altered his storage techniques so that now specimens are placed in separate bottles which are properly labelled.

5. That Respondent's practice of sending less than an entire surgical specimen for pathological study is not medically acceptable.

6. That at the time of the investigation of Respondent's practice there was no means for verification of sterilization procedures.

7. That following the investigation and prior to the conclusion of the hearing, the Respondent began using a strip which verifies adequacy of sterilization procedures.

8. That patients who call Respondent for emergency care are directed by an answering machine to go to an emergency room at a local hospital.

9. That Respondent is contacted by the emergency room when one of his patients arrives for care.

10. That Respondent has coverage by another physician when he is out of the area.

11. That if Respondent is not at home or in the office when he is called, he has a beeper with which he can be contacted.

12. That Respondent's system of coverage, while not ideal, is adequate.

13. That at the time of the investigation of Respondent's practice, it was discovered that vials of testosterone and estrogen used for injections were contaminated with Vitamin B-12.

14. That at the time of the investigation of Respondent's practice the vast majority of the frozen biologicals discovered in Respondent's refrigeration were outdated.

15. That at the time of the investigation of Respondent's practice when questioned about what he would do in the event of anaphylactic reaction, Respondent produced adrenalin which was out-of-date.

16. That following the investigation and prior to the conclusion of the hearing Respondent began to segregate out-of-date vaccines being held for drug company pick-up and reimbursement from the biologicals in current use.

17. That at the time of the investigation of his practice, Respondent gave injections of Vitamin B-12 and testosterone for impotency and fatigue.

18. That Respondent also used injections of Vitamin B-12 for patients who complained of fatigue without performing any laboratory studies to determine if the patients were, in fact, suffering from pernicious anemia which would be an indication for the use of this drug.

19. That there is no medical reason to use Vitamin B-12 alone or in combination with testosterone in the manner Respondent does in his practice.

20. That of the patient records reviewed during the investigation of Respondent's practice, the overwhelming majority reflected that patients were receiving some sort of injection.

21. That many of the records reviewed contained no information which would justify Respondent's use of the particular injectible involved.

22. That Respondent's use of ACTH with antibiotics to treat infections cannot be justified medically.

23. That at the time of the investigation of Respondent's practice, it was determined that when administering penicillin by injection, Respondent simultaneously administered cortisone which he believed would prevent anaphylactic shock.

24. That there is no medical basis for the use of cortisone in connection with penicillin to prevent anaphylactic shock.

25. That following the investigation, but prior to the conclusion of the hearing, Respondent discontinued this use of cortisone.

26. That at the time of the investigation, Respondent demonstrated incomplete knowledge to treat the following conditions:

- (a) Gonococcal urethritis.
- (b) Streptococcal pharyngitis.
- (c) Urinary tract infections.
- (d) Anemia.
- (e) Upper respiratory tract infections.

27. That following the hearing, at the Commission's request, Respondent agreed to submit to a review of his medical knowledge by the Family Practice Program at the University of Maryland, School of Medicine for the purpose of aiding the Commission in its disposition of this case.

28. That the findings and recommendations made by the Family Practice Program have been considered by the Commission only as to the disposition of this matter and not as to the specific factual findings as set forth in paragraphs 1-26 above.

Conclusions of Law

Based upon the foregoing Findings of Fact, the Commission concludes as a matter of law that the charge of professional incompetence has been sustained.

Order

Upon the foregoing Findings of Facts, Conclusions of Law and based upon a review of Respondent's present medical competence and recommendations by Drs. Richard C. Arbogast, Peter M. Hartman and M. William Voss, all of the Family Practice Program, University of Maryland School of Medicine, it is this 9th day of February, 1979 by the unanimous vote of those members of the Commission on Medical Discipline hearing this case.

ORDERED that Respondent is hereby placed on PROBATION subject to the following conditions:

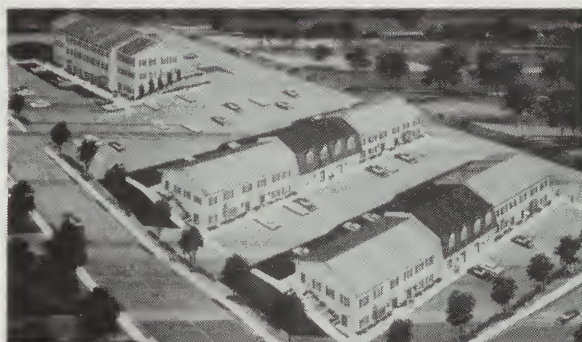
1. That Respondent shall undertake a preceptorship program at his own expense with the program and preceptor to be approved by the Commission.

2. That Respondent shall modify his standards of practice as required by the preceptor.

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3. That Respondent shall submit to quarterly reviews of his practice by the appropriate unit of the Prince George's County Medical Society.

4. That Respondent shall arrange for the preceptor and the unit of the Prince George's County Medical Society reviewing his practice to submit quarterly reports to the Commission evaluating his improvement.

5. That Respondent shall arrange for the preceptor and the Prince George's County Medical Society to submit to the Commission nine months after the date of this Order a report regarding Respondent's medical abilities, and be it further

ORDERED that if Respondent violates any of the foregoing conditions of probation, if the quarterly reports submitted indicate that his medical skills are not improving or if the reports submitted nine months after the date of this Order do not indicate that Respondent has achieved those standards expected from a person engaged in the independent practice of family medicine in Maryland, the Commission may, after notification and a hearing, take any disciplinary action against Respondent's medical license it deems appropriate upon any such showing, and be it further

ORDERED that this Probation shall continue until such time as the Respondent's practice is deemed acceptable by the preceptor, the unit of the Prince George's Medical Society reviewing Respondent's practice and the Commission. In that regard, the Commission shall entertain, one year after the date of this Order, a petition for the termination of the Respondent's probationary status. At that time, should it determine that the termination of probation would not be appropriate, the Commission may alternatively consider a request to modify one or more of the conditions upon which Respondent was placed upon probation; and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with the Annotated Code of Maryland, Article 43, Section 130(m).

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

Discipline Commission Findings
appear monthly in the **Journal**.

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Order

On Feb. 6, 1979, a hearing was held before John E. Adams, MD; John G. Ball, MD; Jerome J. Coller, MD; Vincent Fiocco, MD; Arthur T. Keefe, MD; Francis D. Mayle, Jr., MD; Eli H. Lippman, MD; Karl F. Mech, MD and Frank Shipley, MD, constituting the entire Commission on Medical Discipline. This hearing was convened to consider a petition for reinstatement filed by Paul Schonfeld, MD (The "Petitioner") whose license to practice medicine in Maryland had been revoked on Apr. 26, 1977. Petitioner appeared without counsel. Jack C. Tranter, Assistant Attorney General, was present on behalf of the Commission.

Dr. Adams, Chairman of the Commission, introduced into the record the following documentary evidence that had been forwarded to the Commission by Petitioner.

1. **Exhibit #1**—Packet of letters and other materials forwarded to the Commission.

2. **Exhibit #2(a)**—Copy of a letter dated July 31, 1978 from Edward J. Kowalewski, MD addressed to "My Physician Peers and Medical Institute of the United Kingdom."

3. **Exhibit #2(b)**—Copy of a memorandum dated Aug. 18, 1977 from Edward J. Kowalewski, MD to John E. Adams, MD, Chairman, Commission on Medical Discipline, and Joseph I. Berman, MD, Chairman, Med-Chi Peer Review Committee.

4. **Exhibit #2(c)**—Memorandum dated Apr. 17, 1978 from Edward J. Kowalewski, MD to John Adams, MD, Chairman, Commission on Medical Discipline, and Joseph I. Berman, MD, Chairman, Med-Chi Peer Review Committee.

5. **Exhibit #2(d)**—Copy of a memorandum dated Dec. 4, 1978, from Edward J. Kowalewski, MD to John Adams, MD, Chairman, Commission on Medical Discipline.

Following testimony by Petitioner and questioning by the Commission, the hearing was concluded.

Based on the testimony and documentary evidence the Commission finds:

1. That by Order dated Apr. 26, 1977 Petitioner's license to practice medicine in Maryland was revoked.

2. That the Commission's Apr. 26, 1977 Order indicated that it would entertain a petition for reinstatement of license on or after Jan. 18, 1979 and at such time would consider factors such as Petitioner's efforts to maintain his competence, his involvement in his community and his efforts in the area of Continuing Medical Education.

3. That after the Commission's Apr. 26, 1977 decision revoking his license, Petitioner contacted Edward J. Kowalewski, MD, Professor and Head, Family Practice Program, University of Maryland School of Medicine regarding an educational program that would maintain his competence as a physician.

4. That Dr. Kowalewski recommended a program designed not only to maintain competence, but also to improve Petitioner's practice, attitudes and behavior.

5. That Petitioner has successfully completed the program designed by Dr. Kowalewski.

6. That following the completion of the program designed by Dr. Kowalewski, Petitioner voluntarily continued his educational efforts with the Family Practice Program at the University of Maryland School of Medicine.

7. That Dr. Kowalewski has stated that Petitioner "has achieved a remarkable result in his reeducation effort to the point where, without reservation, we recommend that he be fully reinstituted to the practice of medicine."

Based on the foregoing finding, it is this 6th day of February, 1979 by a majority vote of the entire Commission on Medical Discipline

ORDERED that the license to practice medicine in Maryland issued to Paul Schonfeld, MD which had been revoked by Order dated Apr. 26, 1977 is hereby REINSTATED, and be it further

ORDERED that one year from the date of this Order Dr. Schonfeld shall file a report advising the Commission as to the nature and status of his medical practice, and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with Article 430, Section 130(m) of the Maryland Code.

JOHN E. ADAMS, MD, Chairman
Commission on Medical Discipline

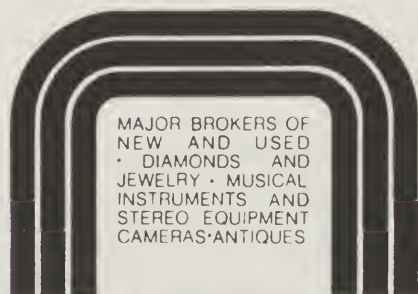
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Maryland Hospital News

Hopkins Reports Use of Safer Prenatal Sickle Cell Anemia Test

A new prenatal diagnostic test for sickle cell anemia is now being used at the Prenatal Diagnostic Center of the Johns Hopkins Hospital. The test, a genetic analysis of fetal cells found in amniotic fluid—the liquid that surrounds the fetus—promises to be safer than techniques which require analysis of fetal blood.

Johns Hopkins is the first medical center in the East to use the technique, and only the second in the country. The test, which is based on the restriction enzyme technology for which two Hopkins scientists, Drs. **Daniel Nathans** and **Hamilton Smith**, won the 1978 Nobel Prize in Medicine, was developed at San Francisco General Hospital by Dr. **Y. W. Kan**. The Hopkins experience with the test is described in a recent issue of **The Johns Hopkins Medical Journal** by a group of scientists including Drs. John A. Phillips, III; Alan F. Scott; Haig H. Kazazian, Jr. and Kirby D. Smith.

Until now, the only prenatal test for sickle cell anemia depended on withdrawing blood samples from the fetus. That method involves increased risk to the fetus and often results in difficult diagnosis if the fetal blood samples become contaminated by maternal blood. The fetal blood test is based on the discovery by Dr. Kazazian, Professor of Pediatrics, that the second trimester fetus makes a small amount of adult hemoglobin.

The new restriction enzyme techniques requires only an amniocentesis, the extraction of amniotic fluid from the mother's womb, a procedure already routine in other types of prenatal diagnosis. The DNA of fetal cells in the amniotic fluid is then mixed with a specific restriction enzyme, a "chemical knife" that cleaves DNA at specific sites. The restriction enzyme "recognizes" a site on DNA near the gene for normal hemoglobin, but this site is absent in the DNA near the gene for abnormal sickle cell hemoglobin. Thus, the length of DNA containing the sickle cell gene is different from the length of DNA containing the normal hemoglobin gene. Since DNA containing most, but not all, sickle cell genes has this different length, couples at risk for sickle cell anemia should consult the Center prior to 14 weeks of pregnancy.

The restriction enzyme technique is also being used to diagnose other types of hemoglobin disorders and, hopefully, in the future these techniques will be used to diagnose other types of genetic disorders as well.

Sickle cell anemia is an inherited disease of hemoglobin, the red coloring matter in blood cells which carries oxygen throughout the body. The disease mostly affects Blacks and some people of Mediterranean origin. The blood cells of people with sickle cell anemia become distorted and form "log jams" in tiny blood vessels, causing painful "sickle cell crises" and organ damage from lack of oxygen.

The disease is a recessive trait, which means that if both parents carry a gene for sickle cell anemia, each

child has a 25% chance of inheriting the disease. About one in every 400 Black babies born in this country has sickle cell anemia. Many face severe complications and shortened lifespans.

Other authors of the article were Drs. Gail Stetten and George H. Thomas. □

Taylor Manor Psychiatric Hospital offers a Prize and Trip for Essay on Psychiatric Emergencies

Award Details

This award is being offered to the medical student, intern or resident under 35 years of age who authors the best manuscript on any aspect of Psychiatric Emergencies (acute functional/organic psychoses, acute confusional states, panic reactions, drug overdoses, etc.). Winner will receive a cash prize of \$250 plus travel expenses to attend and to read the essay at the 12th Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City, MD on **Psychiatric Emergencies: Diagnostic and Management Challenges**, on Apr. 12, 1980.

Manuscript already submitted for publication or published is ineligible. Abbreviations should be kept to a minimum; their use is acceptable in lieu of lengthy terms. Medical abbreviations are acceptable if listed in **Dorland's Medical Dictionary** and the **AMA Style Book and Editorial Manual**. References should be cited in a consecutive manner in the text and not alphabetically by author. They should be listed in numerical order at the end of the paper. Their number is limited to 20.

An original and one copy of the double-spaced, typed manuscript (maximum 3,000 words) must be submitted by Feb. 15, 1980 to Frank J. Ayd, Jr., MD, Symposium Director, Taylor Manor Hospital, Ellicott City, MD 21043. Further details on the competition may be obtained from Dr. Ayd at (301) 465-3322.

This award is being offered in conjunction with the 1979-80 Taylor Manor Hospital Psychiatric Symposia Series.

IRVING J. TAYLOR, MD, Medical Director
EDITH L. TAYLOR, Executive Director
FRANK J. AYD, JR., MD, Symposium Director
FRANCES C. CARD, Symposium Secretary □



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Adams Lecture

The University of Maryland School of Medicine recently announced the endowment of an annual lecture in memory of **Thurston R. Adams, MD**, an alumnus of the School of Medicine and former Professor in the Department of Surgery.

The Dr. Thurston R. Adams Memorial Lecture in Surgery is being made possible by an endowment fund sponsored by the University of Maryland School of Medicine and the immediate family of the late Dr. Adams in recognition of his many contributions to the educational and service programs of the medical school and the University of Maryland Hospital. Tribute fund gifts received by the Medical School in memory of Dr. Adams accounted for two-thirds of the endowment, and, one-third of the fund was contributed by Mrs. Thurston R. Adams, Mr. and Mrs. Thurston R. Adams, Jr. and Mr. and Mrs. Gordon L. Adams.

A prominent alumnus of the School of Medicine (1934), Dr. Adams was Associate Professor of Surgery at the school until his retirement in January, 1978, serving more than 43 years as a member of the Faculty. He was also Chief consulting surgeon for the Baltimore and Ohio Railroad for 35 years.

A sports enthusiast, Dr. Adams was a founder and charter member of the University of Maryland Terapin Club. He also served for long periods as head of the medical school's Admissions Committee and its Credentials Committee.

Dr. Adams was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgery and a member of the

Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland and the University of Maryland Surgical Society.

Franklin Square

Franklin Square Hospital in Essex, MD recently opened a new, short-term, 20-bed inpatient Psychiatric Treatment Center for the care of adults and older adolescents in crisis.

Joseph English, MD, a prominent, national figure in the field of psychiatry, was the hospital's guest for the entire day. Dr. English is the Director of Psychiatry at St. Vincent's Hospital in New York City.

He spent the day with Dr. **M. Lawrence Spoot**, Chairman of the newly-created Department of Psychiatry at Franklin Square, touring the Hospital and the Unit.

He also delivered a scientific lecture on the development of general hospital psychiatry to the medical and house staffs of Franklin Square.

The medical director of Sheppard and Enoch Pratt Hospital, Dr. **Robert Gibson**, was the guest speaker at the dedication, discussing the role of the general hospital in American psychiatry.

Dr. Gibson was joined in the program by psychiatrists from the Baltimore community. An open house and tour of the unit followed.

The Psychiatric Inpatient Unit is an open, unlocked unit, designed for short-term psychiatric care. Patients spend anywhere from a few days to four weeks on the acute unit.

The self-contained unit is equipped with its own kitchen, laundry room and dining area.

According to Dr. Spoot, the treatment program emphasizes

development and maintenance of an individual's coping skills in relation to personal, family, occupational and community adjustment.

"Treatment will be provided by a highly trained staff, including psychiatrists, a psychologist, social workers, psychiatric nurses and a recreation therapist," noted Dr. Spoot.

Individual, family, group and recreational therapies are available in the treatment program. Therapeutic plans are personalized, said Dr. Spoot, and include arrangements for follow-up care within the community.

The full range of medical services provided by Franklin Square are available to individuals on the Psychiatric Inpatient Unit when needed for comprehensive diagnosis and treatment.

In addition, members of the Department of Psychiatry provide consultation-liaison services to patients on all other units in the hospital who need psychiatric evaluation or help.

Dr. Spoot said working relationships have been established with the Eastern Community Mental Health Center in Baltimore County and such relationships will be extended to other mental health clinics and appropriate agencies.

"Our goal in the Department is to work cooperatively with the ECMHC and other mental health centers to make the Psychiatric Unit readily accessible to patients from those centers." □

Coming in the Journal:

Surgical Treatment for Rheumatoid Arthritis of the Hand,

by Homer C. House, MD

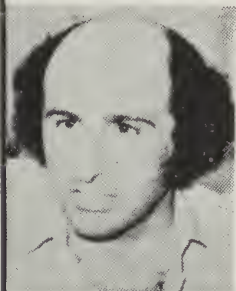
and J.B. Desilva, MD and

Oxytocin Challenge Test

at Maryland General Hospital,

by Norman Levin, MD

and Yung N. Kim, MD



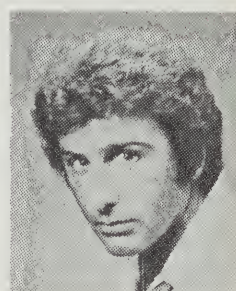
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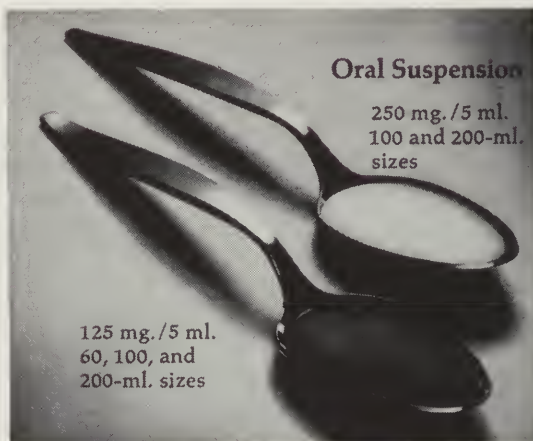
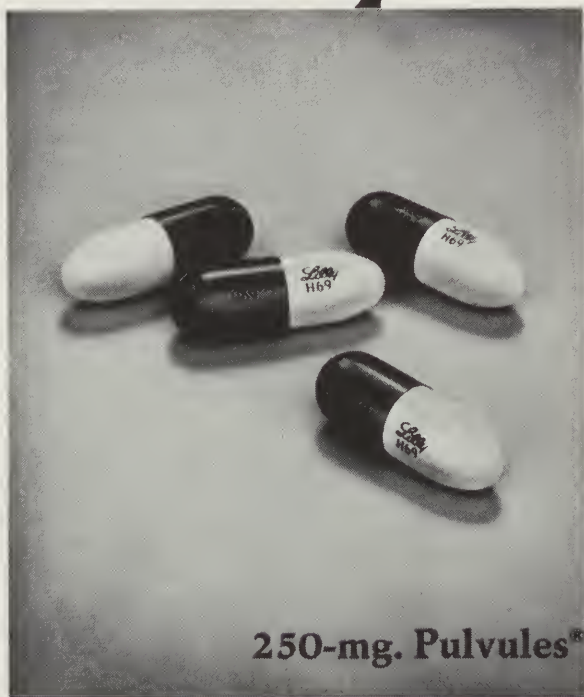
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Cover Story: Health in History

Britain's Admiral Lord Horatio Nelson

By BLAINE TAYLOR

Contact Mr. Taylor, **Journal** Managing Editor, for reprint and further information c/o the **Journal**, 1211 Cathedral St., Balto., MD 21201.

Introduction

Since September, 1975, the **Journal** has been publishing a series of articles describing how health—or the lack of it—has played a significant part in the shaping of international political events and history.

This installment marks the fourth such piece culled from the rich period of the Napoleonic Wars era of 1795-1815, the prior articles being **A Bicentennial Special: England's King George III — The Mad King/A Medical Casefile** (July, 1976); **A Medical View of Napoleon I** (September, 1976) and **Some Medical-Historic Aspects of the Later Napoleonic Wars, 1812-15** (December, 1978.)

Nelson's Place in History

Since its defeat of the mighty Spanish Armada in 1588—and until it was superceded by the US Navy at the end of the Second World War in the Pacific in August, 1945—the British Navy was the globe's greatest. It was confirmed in this preeminent maritime position by a series of brilliant naval victories by the British Empire's most renowned seaman of all time, Admiral Sir Horatio Nelson, a Viscount and Knight of the Bath.¹

These stunning, spectacular victories included the Battles of the Nile, 1798; of Copenhagen, 1801 and the most famous, Trafalgar, off the southwest coast of Spain, in 1805. From that date until the building of the Imperial German battlefleet a century later, Britannia's dominion over the waves wasn't seriously challenged. The major credit for these naval triumphs has been universally given by historians of the period to Nelson himself, while he, in his day,

"Gave his men credit...He believed the boldest measures were the safest. Nelson was a fearless leader and patriot."²

Alongwith his contemporary and military peer on land, the Duke of Wellington, Admiral Nelson proved to be the undoing of their



ADMIRAL SIR HORATIO NELSON in 1801, the year of his victory over the Danish fleet and shore batteries at Copenhagen. (Portrait by John Hoppner.)

greatest mutual enemy; revolutionary (and later Imperial) France, as personified by General Napoleon Bonaparte, who became Napoleon I as Emperor of the French in May, 1804. Nelson's victory at sea at Trafalgar the following year both crushed the French Navy and prevented—once and for all—the long-threatened Napoleonic invasion of the British Isles, while Wellington's triumph a decade later at Waterloo in Belgium wrote finis to Napoleon's military power, as well as sending him, personally, to his last, fatal exile on the Island of St. Helena.

Oddly enough, these two greatest figures in the history of British arms chanced to meet only once, in the British Colonial Office, when Nelson was already world-renowned, and Wellington was merely a rather obscure British Army officer.

As Wellington later told the tale:

"He could not know who I was," recalled Wellington, "but he entered at once into conversation with me, if I can call it conversation, for it was almost all on his side and all about himself, and in, really, a style so vain and silly as to surprise and almost disgust me.

"I suppose something I happened to say may have made him guess that I was **somebody**, and he went out of the room for a moment, I have no doubt to ask the door-keeper who I was, for when he came back he was altogether a different man, both in manner and matter. All that I had thought a charlatan style had vanished, and he talked of the state of the country and of the aspect and probabilities of affairs on the Continent with a good sense, and a knowledge of subjects both at home and abroad, that surprised me equally and more agreeably than the first part of our interview had done; in fact, he talked like an officer and a states-

man . . . I don't know that I ever had a conversation that interested me more."³

This illuminating passage well points out "The exhibitionism which had first become apparent in an insecure Rear Admiral . . ."⁴ and this despite the fact that, at the time of the meeting, Nelson was acclaimed, far and wide, as "The Hero" of the nation⁵ and **this** despite the Admiral's long-standing, scandalous, extramarital love affair with the Lady Emma Hamilton, whose husband was one of Nelson's best friends!

The Physical Horatio Nelson

A slim, frail, enigmatic figure, Nelson was an unlikely naval paragon. He . . . "was so puny as a child that his uncle, Capt. Maurice Suckling, once exclaimed, 'What has poor Horatio done . . . that he should be sent to rough it at sea?'"⁶

Moreover, to state it mildly, "Nelson had physical problems: loss of an eye, arm amputation and, finally, he was felled by a bullet in his spine. Nelson twice suffered tropical diseases and went to Canada to recover."⁷ Nelson's self-deprecating wit in later years led him once to compose a limerick on his various afflictions:

"Wounds received by Lord Nelson:
His Eye in Corsica
His Belly off Cape St. Vincent
His Arm at Teneriffe
His Head in Egypt
Tolerable for one War."⁸

One of Nelson's many biographers—A.B.C. Whipple—described him thus as he prepared to put to sea on Sept. 13, 1805 to

find Napoleon's invasion fleet: " . . . a lone, frail figure of a man bracing himself with his left arm as the carriage lurched . . . The man wore the uniform of a Vice Admiral in the Royal Navy. His empty right sleeve was pinned to his coat. His right eye was blind . . . that slight, straight figure . . . half-blind, one-armed man . . ."⁹ The many years spent at sea took their toll on Nelson's never very hardy constitution; by 1797—when he was 39—"His body was shrunk into his uniform. His once-blond hair was white. A livid scar creased the right side of his forehead."¹⁰

Like the young Teddy Roosevelt (who also was a puny, sickly child) later, Nelson strove to overcome his frailties by rising above them through sheer willpower and force of determination—and succeeded. His demanding physical lifestyle, however, wasn't conducive to his overall health, but **did** allow him to accomplish the tasks he set himself: to live a life of glory and to destroy the French fleet.

"Nelson usually rose with the daylight . . . had breakfast with some of his officers and aides in his dining cabin at 6 AM. By 7:02, he had taken a quick walk about the deck and was back in his cabin, going through all the paperwork required to keep his fleet afloat . . . the **Victory's** Chaplain, Dr. Scott . . . had to do most of the reading for Nelson, whose one eye had become so weak that the **Victory's** doctors would not let him use it for more than short periods . . . At noon . . . Nelson usually emerged from his quarters. For three hours, he would pace the deck . . . he kept it up until dinner-time, which, aboard the **Victory**, was 3 PM . . . the Admiral's dinner usually included three courses, a dessert and even wines, but Nelson ate little of it. Too much food upset his stomach or made him seasick . . . After dinner, he would hold conferences with captains of the fleet . . . or go over more reports and letters. Then, he would return to the deck, to continue his ceaseless pacing. Before nightfall, he would walk the deck for five or six hours, covering more than 15 miles every day. By 7 PM, he was back in his cabin for tea and a bit of supper with his officers. The officers usually had a 'nightcap'—a glass of punch and a piece of cake or biscuit—at about 8. Nelson often joined them . . . He was always in his cot by 9. Always, that is, when things were going well.

"But on many of those cold, blustery nights off Toulon, when the crew had had their second tot of grog and their supper and the hammocks had been slung again, the men on the upper gun deck, swinging in their hammocks and trying to sleep, could hear the steady footfalls on the planks only a few inches above their heads. As the green seas broke over the bows, water dripped

A Nelsonian Chronology, 1758-1806

- 1758 — Sept. 29th, born
- 1771 — Joins Royal Navy at age 12
- 1775 — Fever in India
- 1780 — Fever recurs in Nicaragua
- 1781 — August, back at sea after recovery
- 1782 — Ill with scurvy in Canada
- 1787 — March 11th, marries Frances Nisbet
- 1793 — Opposes Napoleon for first time at Toulon
- 1794 — July 12th, blinded in right eye at Corsica
- 1797 — Feb. 14th, Battle of Cape St. Vincent
July 25th, loses right arm at Teneriffe
- 1798 — Aug. 1st, Battle of the Nile; headwound
- 1801 — Daughter Horatia born;
Promoted Vice Admiral of the Blue;
Apr. 2nd, Battle of Copenhagen
- 1802 — April, Nelson ill
- 1804 — June, Attains highest rank
- 1805 — Sept. 29th, 47th and last birthday
Oct. 21st, Battle of Trafalgar and death of Nelson
- 1806 — Jan. 8th, funeral and burial, London. —Table by Blaine Taylor

through the planks into their hammocks. Waves washed through the anchor hawseholes, swishing across the deck and floating the debris of the livestock pens under the sailors' hammocks. The **Victory** groaned and creaked as she worked her way through the heavy seas, but in the pauses between the groaning and the swishing and the pounding, the men could hear it again, sometimes all night long—the steady thud, thud, thud as Lord Nelson paced his lonely way back and forth on the deck of the **Victory**.

The **Victory's** doctors would sometimes wake and worry too. They knew that Nelson was out there on the sea-swept deck in near-freezing temperatures, wearing only a light coat which would soon be soaking wet, and when he returned to his cabin in the early hours of the morning, he would kick off his shoes and walk about his cabin in wet stockings rather than rouse his manservant to take them off. Officer's stockings in those days were tightly fitted and rose to the knee, and Nelson couldn't remove them with his one hand, but the doctors knew that it did no good to argue with the Admiral about how he was endangering his health; they had tried that too many times before, with no success... Nelson developed a racking cough (this was in December, 1804—ed. note.) It weakened him and made him lose weight, and he could not get rid of it."¹

Hazards of the Sea

Life at sea and maritime warfare during the late 18th and early 19th Centuries—as you may have already deduced from the foregoing passages—was no picnic. Essentially unchanged from the days of the Spanish Armada centuries before (and until the American Civil War decades later), the milieu in which Nelson lived most of his life was harsh and unrelenting. He entered it as a midshipman at age 12.

As author Whipple relates:

"As a midshipman, Horatio was crowded into a tiny cabin area with so many others that there was barely room to swing a hammock. On the first windy night, many of the other new boys were seasick. So was Nelson. The ship was battened down, with every opening closed to keep out the flying spray. As everyone grew sicker, the air itself became nauseating.

Through the ship's thick sides could be heard the pounding of the sea, the crash of the waves and the howling of the wind. Inside the cabin, there was the moaning and the retching of seasick sailors. Young Horatio Nelson learned what it took to be a sailor on that first stormy night at sea.

In the next few days and weeks, he learned a great deal more. He learned his way about the floating world of his warship. He learned how hard it was to climb out on a wet yardarm high over the roaring sea on a stormy night. He learned how the British Navy recruited and treated its men. He learned how the men sometimes rebelled, and what happened to them when they did. Above all, he learned to be a naval officer in the finest tradition of the best navy in the world...

To a boy going to sea for the first time, she was a huge ship, with masts so high they made him dizzy and sails that seemed to cover the sky. She carried row on row of big guns along her sides—64 of them, almost enough for a boy to lose count; yet the big ship always seemed crowded below. In the quarters Nelson shared with other young midshipmen, there was space only for his hammock and scarcely any room for stowing his gear, but he was far better off than the seamen in the lower decks. Down below the waterline, there were no portholes and the only light came from lanterns—even in the middle of the day. The men quartered there were so crowded that they could lie in their hammocks and not even swing to the roll of the ship, so closely were they packed.

In fact, a warship in those days did not have enough room for the entire crew to sling hammocks at any one time. The crew was divided into watches, with half the men working while the other half rested or slept...

Much of the work was done aloft, on yardarms higher than a housetop. From the deck he was forced to climb up the rigging until the sailors below looked like midgits. There he could stand on a tiny platform until he got used to the fact that he was swinging far out over the water with every roll of the ship. Then he had to crawl out along the yardarm, hanging on as he tried to keep from missing the footrope and falling while the ship plunged under him. At first, like all new hands, he tried to work with one arm, using the other to hang on for dear life, as he furled sail, but soon an officer was shouting at him, or swinging a knotted rope at him, to make him work with both hands.

Sometimes, when the breeze was light and the ship ran along on an even keel, it was pleasant to stand on the footrope and lean over the yardarm, looking down at the blue sea swishing by and daydreaming as the wind sang softly in the rigging, but then there were nights when all was black and the gale screamed and the sails thundered and the ship plunged so that the masts seemed to keep going right on over into the water. On nights like this, Nelson had to work harder and faster than ever. If he did not, the ship might sink in the storm, taking all hands down with her.

Often the footropes and yards were covered with ice. If a sailor's fingers, numb with cold, fumbled and let go, he could pitch from the swaying footrope into the empty blackness below. If the ship were at that moment swinging out over the sea, he would drop like a cannonball and sink so deep that he could not hold his breath long enough to struggle back to the surface. Even if he did, there was little chance that the ship could come about and find him in the dark stormy waters. His cries would not be heard above the shrieking of the storm, but the sailor who fell into the sea and drowned died a less painful death than the one who plunged onto the deck. A fall like this was enough to break nearly every bone in a man's body, and the ship's surgeon could do little but try to comfort him through his hours of agony until he died. It was a very lucky sailor who happened to fall into a sail. If his comrades worked fast, they could haul him back onto the footrope, still alive but scared within an inch of his life.

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Sometimes it was just as dangerous on deck. In a pitching sea, one of the huge guns could break loose from the ropes that held it to the gun port at the ship's side. Each gun weighed hundreds of pounds and was set on wheels so it could be rolled back and forth at its port. When one broke loose and slewed around, the iron monster could roll the length or width of the deck, crushing anything in its way. The only way to stop it was to get a long iron bar under the gun and heave it over on its side. Only a brave man would try that on a slippery, rolling deck.

When the weather grew rough and cold, there was always the chance of being struck by a shipmate falling from above, and when the seas rose higher and the ship plunged her bow under the towering waves, the hissing green water poured aboard and swept the length of the deck. Any sailor who was not ready to grab hold of something could be picked up like a cork in this boarding sea and carried over the rail.

There were plenty of men aboard Nelson's ship who had not joined up willingly. If the Navy had waited for volunteers, it would never have been able to complete a crew for any of its warships. In those days, a man could be walking the streets of a port town like Chatham or Liverpool one minute and, the next thing he knew, wake up in a hammock aboard a ship—after being knocked unconscious and kidnapped by a 'press gang.' These press gangs were roving bands authorized to capture men for service as sailors...

It was a rough and rebellious crew that manned most ships of the British Navy in those days, and the officers used rough methods to keep them working. The seaman's 'on watch' usually started with the shriek of the boatswain's whistle and the bellow of the mate: 'All hands ahoy!' and 'Up all hammocks ahoy!' Every man moved fast; if he did not, the mate 'started' him with the flick of a knotted rope's end. When the work was not dangerous, it was long and dreary: scrubbing decks, tarring ropes, painting the ship's sides, shifting sail to make the most of every slant of wind.

For their labor, the men were paid what amounted to a few dollars a month, and they did not receive that until they were released, sometimes after years of service. The food was often spoiled and there was usually not enough of it. Many of the officers believed that the only thing that could make good seamen was the harshest form of discipline. Any sailor who moved too slowly or grumbled over the work or the food was 'corrected' by the whistling end of the knotted rope or the heavy end of a marlinspike. There were even Navy regulations against swearing. An ordinary seaman caught using profanity was forced to wear a heavy wooden collar and pace up and down the deck until he was ready to drop. One captain added two 32-pound shots to the collar and nearly broke the man's neck.

If a sailor made the mistake of talking back to a superior or falling asleep on watch, he received far sterner punishment. Taken below and chained, he was given a length of rope and ordered to make his own cat-o-nine-tails. Then he was taken on deck, because in the crowded quarters below decks there was 'not enough room to swing a cat.' On deck, the sailor was stripped to the waist.

His wrists were tied and hoisted. Then he was lashed with the cat he had made, until his back was a bloody pulp. The bleeding back was doused with salt water, partly to add to the punishment, but mostly to clean the wounds. Aboard British naval ships in the days when Nelson went to sea, this was an almost everyday occurrence.

Often the men rebelled, in hidden ways and in the dark of the night. An officer would fall down a companionway because someone had left a bucket on the steps. A marlinspike would drop from aloft and knock an unpopular mate unconscious. A 32-pound cannonball would roll the length of the deck, thundering down on an officer and crushing him against the rail if he did not jump quickly out of its path. Rarely were the seamen who tried such tricks of revenge found out. Woe to them when they were.

Some sailors who could not take the abuse and punishment tried to desert. It was not easy. Whenever a naval ship was in port or near land, a marine sentry was constantly on duty, patrolling the special 'marine walk' to watch for any attempted desertion. If a man did get away, he was hunted down by the Navy. If he was caught, his punishment was far worse than he had had before. A 'run man' was taken back to his ship and sometimes 'flogged through the fleet,' as an example to others who might be planning to jump ship, he was taken in a boat and flogged before every vessel in the fleet. His punishment was usually stopped before he died, and he was put back to work as soon as he could walk again.

With conditions like these—press gangs kidnapping the worst waterfront riff-raff and naval officers trying to beat them into submission—it was no wonder that there was sometimes open mutiny...

And yet it was the greatest Navy in the world. It was the Navy that beat France, the Navy that captured or sank all but one ship in the American Navy in the Revolutionary War. It was the Navy that made England a great power...that kept Napoleon from conquering most of the world.

How could England's sailors be so poorly treated, so rebellious and such good sailors, and fighters all at the same time? One good reason was Englishmen like Nelson... English sailors were great patriots. Every man was more than ready to die for his country. None could think of greater glory than bravery in battle for England. Even during the famous mutiny at Spithead, which happened while England was at war with France, the mutinous sailors announced that if the French Fleet should put to sea, the mutiny would be postponed.

A more important reason was that the British Navy was the first in the world to train its officers professionally instead of simply letting a wealthy or titled man, with no experience or training, purchase his officer's commission. British naval officers, schooled by harsh discipline, were proud of their competence, and this competence was recognized by their subordinates.

Most of the officers saw to it that discipline was maintained, but with fairness to all, and these officers won the affection as well as the respect of their men...¹²

Maritime combat in those days was—as on land during the

Napoleonic Wars¹³—a brutal, savage affair. For instance, Nelson's famed flagship, HMS **Victory** (still on view today at Portsmouth, England), launched in 1765 (making her 40 years old in 1805 at the time of Trafalgar), carried 104 cannons (some even in Nelson's own sleeping cabin!) that hurled balls in weight ranging from 12-68 pounds.¹⁴ The damage that these could—and **did**—do to men and wooden ships was fearful, indeed, as described by author Whipple:

"Bulkheads were . . . taken down, so that each deck was one clear space with no interrupting walls. Tables, chairs and all other movable objects were carried down to the hold or made ready to tow astern in boats during battle. This was because a cannonball could split a table or chair into huge flying splinters that could drive through a man like so many spears . . .¹⁵ sand . . . had been spread on the decks to keep them from getting slippery when covered with blood. On the gun decks, he studied the short caronades, the guns that were called 'smashers.' They were being loaded with round shot and musketballs, which would spray like gigantic buckshot across the enemy decks. Other guns would fire chain shot, which would whip around anything it hit. Others would fire fagot shot, pieces of iron that would slice enemy sails and cut away rigging . . . '32-pounders' could throw a great, 32-pound cannonball with enough force to drive it through a hull a mile and a half away. Around these guns stood the gunners, stripped to the waist and wearing handkerchiefs around their heads. When the firing started, they would slip the handkerchiefs over their ears so they would not be deafened by the roar . . .¹⁶ Others filled buckets and doused the decks, hammock nettings and sails to avoid fire . . . the men . . . noticed that the smooth water around the ship was cut by the fins of sharks, circling and waiting . . .¹⁷ The **Victory** rocked as her broadsides went off. Hundreds of pounds of iron, chain and musketballs screamed . . . and swept the length of the French ship. French guns were knocked over. Gunners were mown down. As the **Victory's** gunners raced to reload and fire again, they could hear the wild screams of the enemy wounded. Through their gunports, they could see the French lying in piles all over the deck; 300 men aboard the **Bucentaure** were killed in one broadside from the **Victory** . . .¹⁸

In addition to the above hazards of sea warfare, there was fierce hand-to-hand combat once enemy ships became entangled from rigging and wrought-iron grappling hooks designed especially for the purpose (and as seen in numerous Errol Flynn pirate movies of the 1930s.) Nelson, himself led several boarding parties (as we shall see), and the weapons used

during these ferocious *mélees* included dirks, daggers, officers' swords, cutlasses, pikes, pistols,

axes and the blunderbuss (a short, shotgun-like weapon with a wide muzzle.) From the riggings,



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marines of the opposing vessels fired down onto enemy decks with long-barreled muskets (and it was to a French marine, as we shall also see, that Admiral Nelson ultimately fell victim.)

Military Medicine at Sea

The practitioners of military medicine of the period did what they could to deal with such wholesale bloody carnage as resulted from the battles described above. States author Whipple:

"And on the lowest (orlop) deck, the ship's surgeon and his helpers prepared their instruments for the bloody work they would have to do when the wounded were brought below. Alongside the surgeon's operating table stood large wooden tubs. These would measure the grisly price of heroism—in the numbers of arms and legs the surgeon would have to amputate...¹⁹ Nelson's secretary...walked up to make a report...and suddenly fell to the deck, cut almost in two by a shot. The marines quickly picked up the body and tossed it overboard before the blood made the deck dangerously slippery...²⁰ In the dim cockpit, there were the groans of the wounded, the cries of the young midshipmen unable to fight back tears, and the sudden piercing shriek of a man whose arm had to be cut off without any pain-killer except a gulp of rum...²¹

Author John Terraine, a

chronicler of the Battle of Trafalgar, has recorded some eyewitness accounts of the carnage:

"For the ordinary seaman, surgery was on a first-come, first-served basis..."

"Mr. Chivers, surgeon of the *Tennant*, told me a man who was working one of the quarter-deck guns was shot through the great toe; he looked at his toe, which hung by a fragment of skin, and then at his gun, and then at his toe again; at last he took out his pocket knife, gave it to his comrade and said, 'Jack, cut that bit of skin through for me.' 'No,' says the other, 'go down to the Doctor, man.' 'Damn it, I'm ashamed of going down to him for this trifle, just whip it off for me, it's only a bit of skin.' In this way, they were going on, when the carronade near him took a cant accidentally, from a roll of the ship, and crushed the whole of that part of his foot; he was then obliged to leave the deck, but is now on board, and doing well."

Another anecdote came from the captain of the *Leviathan*. Like many others of the wounded, including the Spanish Admiral Gravina, the sailor described in this letter later died from gangrene...a shot took off the arm of Thomas Main, when at his gun on the forecabin; his messmates kindly offered to assist him in going to the surgeon, but he bluntly said, 'I thank you, stay where you are; you will do more good there.' He then went down by himself to the cockpit. The surgeon (who respected him) would willingly have attended him in preference to others, whose wounds were less alarming, but Main would not admit of it, saying, 'Not until it comes to my turn, if you please.'

The surgeon soon after amputated the shattered part of the arm, near the shoulder; during which, with great composure, smiling, and with a steady clear voice, he sang the whole of 'Rule Britannia!'

Even when the wounded were taken below, they were not safe from further injury, as the following account makes clear. The writer of this letter was an Army officer serving aboard the French ship *Pluton*:

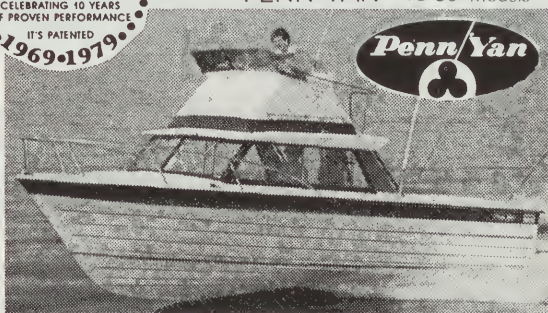
'A cannonball, penetrating the main gun deck, killed two men and wounded several others, including myself. I fell, bathed in the blood of myself and of the dead. I was unconscious for some time. When I came to, I recognized the voice of one of my soldiers, whom I asked to take me to the surgeon's post. He told me that he would already have done so, but had thought I was dead. I was wounded in three places. In the left eye, which I thought I had lost, but which has been open for four days now. In the left hand, which will be the longest to heal; and the one which has caused me the greatest pain was the blow I received on my weak chest, near the collar bone and from one shoulder to the other. It was swollen by four or five inches for five days.

After this, when I was stretched out on a mattress, I was again wounded in two places on my head by splinters thrown by a cannonball which passed through the orlop deck and which killed a surgeon—this shows the poor quality of our ship, even though it is new. What makes things worse was that at first I could not see, and later a dozen wounded fell on to my body, making me suffer considerably. They had to dress my wounds again.'"²²

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Disease A Greater Foe Than Battle . . .

As with Napoleonic warfare on land,²³ "Even during wartime in the 18th Century, more sailors were killed by disease than by the enemy. Aboard a crowded, badly ventilated warship, the men suffered from rheumatism, pneumonia and tuberculosis. The worst killer aboard ship was scurvy, a disease caused by lack of fresh fruits and vegetables. British doctors had found that it could be cured by lime juice (which led to the slang name 'limey' for Englishmen.) . . . The most dreaded shipboard killers in these years, especially in the tropics, were the fevers—typhoid fever, yellow fever and malaria. There were no known cures, and about the only treatment was quinine, which lowered the stricken men's temperature, but did nothing to fight the disease itself. . . ."²⁴

Nelson's own, personal early experiences as a young midshipman led him to have a lifelong compassion for his sailors that later came to be called "the Nelson touch."²⁵ A strong believer in preventive medicine for his sailors, "Nelson tried to ease their life. He saw to it that fresh provisions were brought out . . . There were oranges and lemons to prevent scurvy. Nelson liked to remind the Admiralty that 'It is easier for an officer to keep men healthy than for a physician to cure them . . .' He even demanded flannel shirts with longer shirrtails, because the men had to lean over so far while out on the yardarms taking in sail during snowstorms . . ."²⁶

A Meteoric Career

"Nelson was born on Sept. 29, 1758, at Burnham Thorpe, in Norfolk, where his father, the Reverend Edmund Nelson, was rector. His mother died when he was nine. He was known as Horace by his 11 brothers and sisters. He grew up within sound of the sea, and is said to have learnt to sail on the local tidal creeks before he joined the Royal Navy in 1771 . . ."²⁷

" . . . his ship rolled gently through the brilliant blue waters of the Caribbean. He watched dazzling white islands rise out of the sea. He walked along pink beaches and listened to the wind sigh through palm trees and the water suck in and out of coral caves. He turned brown under the hot, dry sun of the West Indies . . . He tasted West Indian

rum, smelled tobacco drying and listened to the chatter of parakeets and the crooning song of the natives in the soft evening air. He came home to England a sun-bronzed, muscular young man . . ."²⁸

It is a tenet of Nelsonian lore that he possessed courage bordering on the foolhardy, which made itself apparent early in his career: "At 14, he went in the **Carcass** on a voyage to discover the North Pole. It was on this trip that he nearly lost his life to a polar bear which he was trying to capture single-handed in the dark, on the ice. His musket misfired and he escaped being mauled only by the firing of a gun of the **Carcass**."²⁹

Like his enemy and contemporary Napoleon . . . and, later, Erwin Rommel and George Patton—Nelson was absolutely fearless in battle and generally in the van of the thickest fray. Nor was he modest about his bravery, as this personal account of one such engagement reveals:

" . . . perhaps my personal courage was more conspicuous than at any other period of my life. In an attack of the Spanish gunboats, I was boarded in my barge with its common crew of 10 men, Cockswain, Captain Fremantle and myself, by the Commander of the gunboats. The Spanish barge rowed 26 oars, besides officers, 36 in the whole; this was a service hand-to-hand with swords, in which my Cockswain, John Sykes (now no more) twice saved my life; 18 of the Spaniards being killed and several wounded, we succeeded in taking their Commander."³⁰

Indeed, Nelson's propensity for personally leading boarding parties aboard enemy ships had him once using one opponent's vessel (already captured) to take a second,

leading one wit to call the device "Nelson's patent bridge for boarding first-rates."³¹

By the year 1801, he'd fought 105 naval battles (and called Copenhagen "The most terrible of all")³² and, in most of these—particularly in the major engagements such as the Nile—his fleet was heavily outnumbered by the enemy (as at Trafalgar, where the combined French/Spanish fleet numbered 40 vessels to his 34),³³ but his credo was—like Napoleon—always to attack first.³⁴ He would fight rather than not, and preferred being at sea to being idle.³⁵

A very religious man by nature, Nelson was, nonetheless, a believer in destiny. He was obsessed with the belief that he was destined to be England's greatest naval hero—and was, Custer-like, bent on achieving glory for himself, the Royal Navy and his country. As he once wrote to his mistress in the third person (a device later affected also by Gen. Douglas MacArthur, among others), "Nelson must stand among the first or he must fall."³⁶ Writes author Terraine, "Westminster Abbey was his objective,"³⁷ (although he was, in fact, buried at St. Paul's in a coffin fashioned from a mast of the enemy flagship at the Battle of the Nile.³⁸

His courage and his fatalistic view of death were rooted in his religious beliefs:

"When I lay me down to sleep, I recommend myself to the care of Almighty God, when I awake I give myself up to His direction, amidst all the evils that threaten me, I will look up to Him for help, and question not but that He will either avert them or turn them to my advantage, though I know neither the time nor the manner of

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my death, I am not at all solicitous about it because I am sure that He knows them both, and that He will not fail to support and comfort me."

Such faith, combined with professionalism, ambition and a conviction of high destiny, was a battle-winning weapon."³⁹

Despite a lifelong tendency to disobey orders with which he did not agree (as we shall see),⁴⁰ Nelson was as popular with his superiors as with his junior officers (whom he called his "band of brothers"),⁴¹ and won rapid promotion: he was a Captain at 21, an Admiral at 39.⁴² So popular was he with his sailors that, once, "Nelson was presented with an extraordinary petition. If he was taking command of another ship, . . . his crew would gladly give up shore leave in order to transfer with him . . ."⁴³

The young officer was described in these early days of his career by Prince William Henry (his friend who, in 1830, as William IV, became King of England) as "The merest boy of a Captain I ever beheld, dressed in an antique, full-laced uniform, unpowdered, straw-colored hair and a pigtail a foot long."⁴⁴

Nelson's Love Life

During recuperation from scurvy at a hospital in Quebec, Canada in 1781, Nelson fell in love with a girl 16 years old, while he was 23, and nearly resigned from the Navy in order to marry her, but was talked out of his impulsiveness by his colleagues.⁴⁵ (This incident presaged his later reckless love affair with Emma Hamilton.) After some other brief encounters, Nelson met his then-widowed future wife, Frances Nisbet (nicknamed Fanny), and married her on March 11, 1787, at age 29.⁴⁶ He was faithful to her until he met the already-married Mrs. Hamilton during a recuperative shore leave at Naples in Italy in 1798 after the Battle of the Nile.⁴⁷ Their illegitimate daughter (and his only child), Horatia, was born in 1801.⁴⁸ The affair scandalized all Europe (leading King George III to snub Nelson and Emma at court.)⁴⁹ Fanny left him (but never gave Nelson a divorce)⁵⁰ and the Admiral remained passionately⁵¹ true to the fat⁵² Emma (who was also a heavy drinker⁵³) until his death.

Early Nelsonian Illnesses

The earliest known Nelsonian illness was his contraction of a fever (some feel it was malaria) during a voyage to Bombay, India in late 1775.⁵⁴ Writes A.B.C. Whipple of this incident:

"The fever, added to India's sweltering heat, quickly took the weight and muscle off the figure that had been so robust in the West Indies and the Arctic. Then came paralysis. The squadron's chief surgeon could do nothing; all he could recommend was that the patient be put aboard the first ship returning to England. That was the **Dolphin**, a new frigate with comfortable quarters that must have been welcome to the desperately sick young man. He was carried aboard, 'almost a skeleton,' as he remembered it later, and the **Dolphin** made ready to sail for England and home.

The voyage took six months. The cool air seemed to have no effect on the fever. Nelson wasted away even more, and few of those who were caring for him thought he could last much longer, but, with agonizing slowness, he began to grow a little better. The **Dolphin's** captain . . . took pity on the suffering midshipman and spent hours trying to cheer him up. Finally, as the **Dolphin** rounded the Cape of Good Hope and made her slow way into northern waters, the young midshipman started to recover.

Nelson's near-death in India had an effect that lasted throughout his life. Never again was he the sturdy, strong, muscular young man who had returned from the

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West Indies and the Arctic. Always he would look short, slight and frail. Whenever he touched at tropical ports again, there was a recurrence of the old fever, but the experience had an even more profound effect on him mentally than physically. During the weary, six-month voyage home, he had more time for thinking than ever before. At first, when he was unable to throw off the gloom left by the fever, he 'almost wished myself overboard.'

Nelson's mental recovery finally came about in an odd way. One hot afternoon, as the *Dolphin's* sails slatted back and forth on an almost airless sea, the fallow-cheeked young man lay on his bunk and tried to think of his future. He might never be completely healthy again. He had been struck down in the prime of his youth, before he had even started the long climb of promotion in the Royal Navy. He could see nothing ahead but the bleak prospect of a sickly, useless life, but then, for no reason at all, as he described it later, the world and his outlook on it were transformed.

'A sudden glow of patriotism was kindled within me, and presented my King and Country as my patron,' he later wrote. As this emotion surged through him, the young midshipman made a vow that would shape the course of his life—and of England's history. 'Well then,' I exclaimed. 'I will be a hero... I will brave every danger.'⁵⁵

Back in England, Nelson was posted to another vessel in September, 1776, and was sent in 1780 on an infantry expedition against the Spanish in far-off Nicaragua in Central America, capturing Ft. San Juan, but suffered a recurrence of his fever that buried 180 of his 200 men⁵⁶ (although the numbers who died vary from one book to another in the Nelsonian literature.) He was forced to return to England, where he... was an invalid for some months.⁵⁷ His recall from Ft. San Juan by the Admiralty is credited with saving his life,⁵⁸ and the convalescent was well enough to return to sea by August, 1781,⁵⁹ but he'd had a difficult recovery, as he wrote on May 17th: "I have entirely lost the use of my left arm, and very near of my left leg and thigh, and am at present under the care of an emi-

nent surgeon in London, but he gives me hopes of a few weeks will move my disorder... When you write to my father, do not mention my complaints, for I know it will make him very uneasy..."⁶⁰

In October, 1782, he wrote that he'd put in at Quebec on Sept. 17th after a bout with scurvy... "having, for eight weeks, myself and all the officers lived upon salt beef; nor had the ship's company had a fresh meal since the 7th of April."⁶¹

During 1787-93, England was at peace, so Nelson wasn't needed by the Navy, but he returned to active duty in the year 1793, which marked his first clash with then-Colonel Bonaparte, a young artilleryman stationed at the French Channel port of Toulon, which Nelson's ship was helping bombard, while the following year witnessed his first serious wounding.

1794: Loss of Right Eye

British Dr. William Gooddy wrote in 1970, concerning Nelson's duties besieging the French-held city of Calvi, on Corsica (the island of Napoleon's birth):

"In 1794, we come to one of the three best-known of Nelson's disabilities, the damage to his vision. Though he is commonly supposed to have lost the sight only of his right eye, from direct injury, he may have had damage to both eyes, worse in the right than the left."⁶²

On Aug. 8th, he wrote Fanny: "...on the 10th of July last, a shot having struck our battery, the splinters of stones from it struck me most severely in the face and breast. Although the blow was so severe as to occasion a great flow of blood from my head, yet I most fortunately escaped by only having my right eye nearly deprived of its sight. It was cut down, but is as far recovered as to be able to distinguish light from darkness, but as to

all the purpose of its use, it is gone; however, the blemish is nothing, not to be perceived unless told. The pupil is nearly the size of the blue part, I don't know the name. At Bastia, I got a sharp cut in the back... You must not think that my hurt confines me. No—nothing but the loss of a limb should have kept me from my duty..."

Some evidence as to the nature of the eye injury is given in the medical certificate: 'Wound of the iris of the right eye, which has occasioned an unnatural dilatation of the pupil, and a material defect of sight.'

John Harness
Physician to the Fleet
Michael Jefferson
Surgeon attending on shore.'⁶³

'Wounded in the face and right eye, much injured by stones or splinters, struck by shot from the enemy. There were several small lacerations about the face; and his eye so materially injured that in my opinion he will never recover the perfect use of it again.'

W. Chambers
Surgeon to the Forces
in the Mediterranean.

Though it is usually supposed that Nelson's sight was ruined by a foreign body, it is possible, on this evidence, that he had a detached retina, especially as little comment was ever made on the appearance of his right eye, and no traumatic changes are seen in his portraits. If there had been much derangement of the eye, it would have been likely to have been obvious. It is true that he often wore a green shade over his eye, but this was on account of pain. Later, the sight of his left eye became less good, and Nelson himself said in 1804: 'My eyesight fails me dreadfully: I firmly believe that in a very few years I shall be stone blind.'⁶⁴

1797: Battle of Cape St. Vincent and Loss of Right Arm

The year 1797 was a milestone in Nelson's career, for three main reasons: on Feb. 3rd, he was promoted Admiral,⁶⁵ on Valentine's Day (Feb. 14th), he disobeyed orders and thereby helped defeat the Spanish at the Battle of Cape St. Vincent⁶⁶ and, finally, lost his right arm on July 25th during an unsuccessful landing at Teneriffe in the

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Spanish Canary Islands.⁶⁷

The night before the landing, Nelson had made out his will,⁶⁸ and tried to persuade his stepson, (by Fanny) not to go on the mission. Luckily for Nelson, as it turned out, the stepson insisted on going.⁶⁹

During the landing, everyone hit the beach and dashed for cover from the bullets and shells that were sweeping the water's edge.

Most of the shot covering the beach was grape—spraying volleys of musketballs that swept the area like buckshot. As Nelson stepped out of the boat and drew his sword, a shower of grapeshot struck him in the right elbow. The blow spun him around and knocked him to the ground. His first reaction was to grab with his good left hand for the sword that had fallen into the sand. It had belonged to his famous uncle, Capt. Suckling, and Nelson considered it a good-luck token, but he was unable to get back on his feet, and the gush of blood from his wound rapidly weakened him until he scarcely knew what was happening.

The men in his boat had plunged on across the beach, searching for shelter from the defenders' fire. Nelson might have lain there and bled to death if it had not been for his stepson. Josiah Nisbet quickly noticed that Nelson was not with those who had crossed the beach, and he returned, looking for him. He found Nelson, lying in a pool of blood near the boat. Calling for help, Josiah collected five men and lifted his stepfather back into the boat...

Josiah took a neckerchief and tied it

tightly around Nelson's arm just above the wound, slowing the flow of blood. The boat started away from the beach, pitching high over the breakers and out toward the ship.

At that point, the cutter **Fox**, which had left the ship at the same time as Nelson's boat, was struck and holed below the waterline. She started to sink, amid the screams of men floundering about in the storm-whipped water. As if at the sound of their cries, Nelson regained consciousness and sat up. Josiah was directing their course for the nearest ship, but Nelson looked across at the sinking **Fox** and ordered the rowers to go over and save the swimming sailors. Josiah argued with him, pointing out that if Nelson's bleeding were not tended by a doctor right away he might die. Nelson refused to listen. While he lay bleeding in the bottom of the boat, the oarsmen turned the boat and rowed over to the sinking cutter. It took almost half an hour to complete the rescue, but many of the **Fox's** men were saved.

By the time the boat reached Nelson's ship, the **Theseus**, the seas were running so high that it looked impossible for anyone to climb aboard. Someone heard the Admiral hail the ship and, realizing that he must be wounded, prepared to lower a chair from the main yardarm. Nelson called for a rope and shouted, 'Let me alone! I've got my legs left and one arm.' He grabbed the rope and hauled himself aboard ship. Then, he said, 'Tell the surgeon to get his instruments ready, for I know that I must lose my arm, and the sooner it is off the better.'

There was nothing to kill the pain of the operation, for anesthetics had not yet been discovered. While the ship's surgeon cut

through the flesh and what was left of the bone, Nelson could only close his eyes and grit his teeth. The surgeon worked fast, because he knew that his patient was weak from loss of blood and chilled by his long ride back to the ship from the beach. He cut off Nelson's right arm high above the elbow, tied off the blood vessels and hoped for the best.

The full shock of the injury did not strike Nelson until much later. Within 15 minutes of the operation, he was calling for his flag captain to ask how the battle was going...

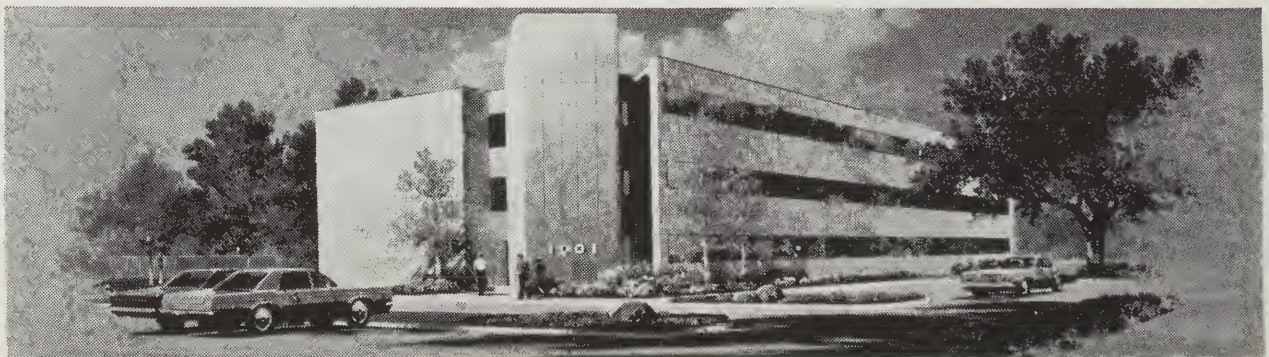
The defeated fleet put out to sea and returned to its base. Then Nelson slowly began to realize how great a personal loss he had suffered. His report of the battle had to be written with his left hand, and it was all he could do to read his own writing. He could not dress himself, and his coat had to be sliced open so the stump of his right arm could fit through. His aides had to cut his food for him when he ate, but, most of all, he suffered from the never-ending pain. He could still feel the breath-taking agony of the cold steel knife. Nelson's wound healed slowly, and one of the ligatures that had tied off a blood vessel would not come loose. All day and night the wound throbbed. Finally he had no choice but to return to England for recuperation.... He had been at sea more than four years....⁷⁰

When Nelson, lying in the sand, recognized Josiah Nisbet, he stated, "I am a dead man,"⁷¹ but, as we have seen, he revived sufficiently to

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clamber aboard the **Theseus**. The ship's surgeon noted in his medical journal: "1797 July 25. Admiral Nelson. Compound fracture of right arm by musketball passing through a little above the elbow, an artery divided: the arm was immediately amputated and opium afterwards given.' Four days later, 'The stump looked well. No bad symptoms whatever occurred. The sore reduced to the size of a shilling. In perfect health. One of the ligatures did not come away.'"⁷²

States author Tom Pocock, "Nelson bore the agony with courage, but the shock of the cold knife was such that he ordered his surgeons henceforth to heat amputation instruments. He was resilient and, next day, the surgeon recorded that he had 'rested pretty well and quite easy.' Tea, soup and sago. Lemonade and Tamarind drink." ⁷³

Author Oliver Warner (one of whose ancestors later examined Nelson's stump),⁷⁴ states that the surgeon who did the amputation was "Thomas Eshelby, who had the help of Louis Remonier, a royalist refugee from Toulon."⁷⁵ (Both Nelson's first left-handwritten letter⁷⁶ and the amputation saw⁷⁷ have been preserved, as has his special "three-tined fork, to which the blade of a knife has been affixed"⁷⁸—and which enabled him later to eat his food with his remaining hand—plus the ball that killed him in 1805⁷⁹ and a death-mask cast afterwards.)⁸⁰

Of the amputation, another source states:

"He did the usual circular amputation at the site of election through the middle third of the arm just below the deltoid insertion where the median nerve crosses the brachial artery. The latter vessel was undoubtedly severed at the time of the injury. The soft tissues must have been very forcibly retracted from the humerus as the ultimate

stump was much shorter than one would expect from the above anatomical description of the site of amputation. Only two ligatures were applied. These were silk and left long, with the ends hanging out of the wound.

After the operation, Nelson was given Pil. Opii grs. ii, and that was repeated during the day and nightly afterwards for some weeks."⁸¹

A Difficult Recovery

The Admiral's initial reaction to his amputation was acute depression, and he even thought of retiring from the Navy. His first letter following the incident was on July 27th (a mere two days later!) to his commanding officer, Sir John Jervis: "I am become a burden to my friends, and useless to my country... When I leave your command, I become dead to the world; I go hence, and am no more seen... I hope you will be able to give me a frigate, to convey the remains of my carcass to England..."⁸² On Aug. 16th, he wrote again: "A left-handed Admiral will never again be considered as useful, therefore the sooner I get to a very humble cottage the better, and make room for a better man to serve the state..."⁸³ and "...a hut to put my mutilated carcass in."⁸⁴

He arrived at Spithead in England in this self-pitying mood on Sept. 1, 1797, where he was acclaimed both in the press and by the public. The stump, however, was **not** healing properly, as recounted by Dr. Gooddy:

"The stump of his arm remained very painful, so that he had to take opium each night. The main cause of the pain was a ligature which had not separated from the wound. The practice of the time was to seal off the blood vessels by tying waxed threads (or silk) round them, leaving the long ends loosely emerging through the stump itself. Eventually, the ligatures were withdrawn by pulling them through the wound and there was the dreadful business of pulling on the ligatures when the wound was dressed, to see if they were yet free or not. This proce-

dures brought with it the risk of secondary hemorrhage, and, naturally enough, from the hazards of amputation done in a few minutes, almost in the dark, in a rolling ship, ligatures must have been inexactly placed, including tissues other than arteries or veins. It seems almost certain that a main nerve of the arm was ligated, either with an artery or separately.

Nelson had a phantom limb, as almost all amputees do; but there are not many allusions to it. He is supposed to have believed in the immortality of the soul because of the persistence of the limb's presence. A letter from his brother states:

'I did this day meet... a surgeon, and esteemed a good one. I mentioned particularly the apparent pain in your right hand. He said it was a sure sign of a nerve being taken up with the artery, indeed he says it is hardly possible to avoid it as there are so many and such small ones: that you must now have patience and all will do well, but he thinks the ligature had better not be forced too much; he thinks you are very safe with Cruikshanks (William Cruikshanks, d. 1800), who certainly is very eminent.'

Nelson's wound was not healing properly and was giving him more pain rather than less as the days went by. The Nelsons therefore went to London, to see if specialists there might be more helpful than the sea physicians of Bath...

I now quote from Oman again:

'At the Admiralty, Nelson learnt, amongst other things, the very welcome news that he was to get a pension of 1,000 a year. Custom decreed that he must first make a formal statement of his services to his sovereign. The document, when accomplished, was impressive. He could claim to have assisted at four fleet actions, three with frigates, six engagements against batteries, 10 cutting-out expeditions, and the capture of three towns, in which service, humbly submitted for His Majesty's consideration, he had lost his right eye and arm.'

There was a standard procedure for uniforms after loss of an arm. The sleeve of the coat was slit to allow an assistant to insert the painful stump into the sleeve, the slit being secured with three bows of black or blue ribbon. All portraits of Nelson showing these bows belong to the four-months period before the stump healed.

Because of the pain, the failure of the wound to heal, and the retention of the ligature, the possibility of reamputation or 'cutting down on the nervebulk' was discussed. The wound became hot and swollen, and was poulticed. Thomas Keate, Surgeon-General to the Army and Surgeon to the


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Prince of Wales, was called in, and advised against 'violent methods.'

On Dec. 3, 1797:

'Nelson went to bed as usual. Outside, the streets were quiet, for it was Sunday night, and there had been three days of intermittent snow. What was unusual was that he slept the night through, waking almost free of pain. He had returned to a sane world, nothing resembling the distorted scene through which he had been forcing his way, almost a soul dragging a corpse, from the moment when he had felt himself hit in the right elbow. The reason might easily be guessed, and when the surgeon (hastily summoned) undid the bandages, the ligature came away at the slightest touch. The knotted thread, attended by evil odors, fell into the dressing like a spent snake, to trouble no more. Within a few days, his stump was fast healing...' ⁸⁵

He returned to sea duty on March 29, 1798.⁸⁶ "...Nelson had some difficulty in settling into his new ship. His luggage was badly packed; he lived at first in great discomfort, and he soon realized the handicap which wounds brought with them. He left England in less high spirits than when he arrived, and it was clear that his servant, Tom Allen, had much to learn if he wished to make his master comfortable."⁸⁷

When he returned to Britain on Nov. 6, 1800, he was even able to joke about the missing limb. A land-lord asked permission to rename his inn **The Nelson Arms**, to which the Admiral replied: "That would be absurd, seeing that I have but one!"⁸⁸

1798: Battle of the Nile (Aboukir Bay) and Head Wound

On Aug. 1, 1798, Nelson at length tracked down Napoleon's fleet to Aboukir Bay off Alexandria, where Gen. Bonaparte had begun his famed Egyptian expedition. The Admiral failed to capture the French commander himself (which would have thus ended Napoleon's career 17 years before Waterloo!), but he came very close. In any event, he defeated the French fleet at the Battle of the Nile, Britain's greatest naval victory since 1588. French Adm. Francis De Brueys was killed ("De Brueys, his legs shot away, had tourniquets tied to the stumps and had himself seated in an armchair on deck until a cannon shot tore him in half")^{88a} and his flagship, **Orient**, blew up,

while "Nelson estimated that 1,400 Frenchmen were killed and 600 wounded; 218 British died and 677 were wounded. More than 3,000 French...were taken prisoner, most of whom Nelson sent ashore so Napoleon's forces in Egypt could care for the wounded. Of the 13 French ships of the line, nine had surrendered and two had burned. Only two had managed to slip out...carrying French Rear Adm. Pierre Villeneuve..."⁸⁹ (whom Nelson would oppose again, at Trafalgar, seven years later.)

As for Nelson, himself during the battle, "...he was 'working his fin,—twitching and stump of his right arm—and angrily giving orders..."⁹⁰

"He was standing on the quarterdeck of the **Vanguard**...when he was hit.

Among the types of ammunition used by gun crews in those days was langridge, a bundle of jagged scrap metal which flew through the air like so many knives when fired from a ship's cannon. It was particularly useful for cutting up sails and rigging, and the French were employing it to good effect. It was a piece of langridge which caught Nelson in the head.

The metal struck him on the forehead and cut through to the bone. Blood poured down his face and chest. The torn flesh fell over his good eye and blinded him. He fell to the deck, but was quickly caught up in the arms of Capt. (Edward) Berry, who summoned help to carry him...deep in the ship below the waterline, the surgeon was at work tending the more than 70 men who had been wounded. Immediately, he turned his attention to the Admiral, but Nelson refused. 'No,' he said, 'I will take my turn...'

When the surgeon finally got to Nelson, he announced happily that the injury was nothing more than a deep flesh wound. The good eye did not seem to be affected, but both eyes had to be covered up by the bandage. The blindfolded Admiral was then led to a cot in the room where the ship's bread was stored, and told to rest.

Nelson promptly called for his secretary, to dictate the news of the victory which he could now send to England. The secretary, who had been wounded himself, took one look at the pale, bandaged Admiral and became so flustered that he could not take down the message. Nelson called for another aide. The new one found that the Admiral had pushed the bandage up off his good eye and was himself scrawling with his left hand: 'Almighty God has blessed His Majesty's arms in the late battle...' ⁹¹

Oliver Warner reports that "The wound temporarily blinded him altogether, and seemed at first so grave that he thought he was dying... Nelson later wrote that, but for his own wound...not

a French ship would have escaped...he was still suffering from the concussion..."⁹² Author Hattersley states that the wound was "...three inches long"⁹³ and that the surgeon's name was Dr. Jefferson.⁹⁴ Nelson arrived at Naples, in Italy, on Sept. 22, 1798 "...with a head which was 'splitting.'" ⁹⁵ "It was more than a year before Nelson recovered fully...and returned to England."⁹⁶

1801: Battle of Copenhagen—"I Have Only One Eye..."

On Apr. 2, 1801, Nelson attacked the Danish fleet, anchored off the port of Copenhagen (the name of Wellington's horse at Waterloo⁹⁷), as well as that city's shore batteries, and won yet another victory. There occurred during the thick of the fighting the most famous incident in all of Nelsonian lore: the blind eye caper (as portrayed on this month's cover). The Admiral's superior—thinking success was beyond British means—signalled Nelson to break off the combat and withdraw.

"Nelson, in the **Elephant**, said to his Captain, Foley: 'You know, Foley, I have only one eye. I have a right to be blind sometimes.' He is said to have raised his spyglass to his right eye, the one injured at Calvi, and announced that he could not see the signal to leave off action. Curiously enough, there was serving in this battle...in the **Glatton**, Capt. (later Adm.) William Bligh, well-known for his association with the **Bounty**, and less well-known, unfortunately, for his having been the master of Capt. Cook's third voyage in 1776."⁹⁸

During the cold, icy voyage to Copenhagen, "One after another, the men came down with colds and pneumonia. Half the crew was sick by the time...the fleet anchored..."⁹⁹—but, reportedly, no one had died. During the battle, however, "More than 250 British had been killed and nearly 700 wounded...the Danes...paid a higher price...nearly 800 killed...900 wounded...2,000 taken prisoner..."¹⁰⁰ Upon returning to England, Nelson's "...first act...was to call at the hospital at Yarmouth, to visit the men who'd been wounded at Copenhagen."¹⁰¹

Interlude, 1801-5

England was at peace until war was declared again on May 18,

1803, when at 4 AM, Nelson left his country estate at Merton to report back for sea duty.¹⁰² Until the Battle of Trafalgar, more than two years later, the Admiral's forces shadowed Napoleon's fleet to prevent the long-dreaded French invasion of the British Isles. "His remaining eye began to grow dim from the strain of the hours on deck... the **Victory's** doctors tried to make him wear a green eyeshade, but it was little help..."¹⁰³

As Whipple reports,

"Then came a wild and agonizing race through Atlantic storms and frustrating calms. By the time the combined French/Spanish fleet reached the French West Indian island of Martinique, nearly 1,000 crewmen had to be sent ashore for hospitalization. Another 1,000 died before Villeneuve was ready to start back to Europe. In contrast, Nelson lost not a single man during the entire chase..."

Nelson ordered the course set eastward, and on July 20, 1805, the British fleet dropped anchor at Gibraltar and Nelson went ashore to see if there were news of the Combined Fleet. It was the first time he had set foot off the **Victory** in two years...

Nelson was exhausted. He was weak and sick from too much tension and too little sleep. He knew that he had probably saved the British West Indies, but that was not enough. He was utterly discouraged by the two years he had spent trying to catch Vil-

leneuve and make him fight. Nelson took the **Victory** into Portsmouth for a much-needed overhaul. He was rowed ashore in his barge. He made his courtesy call on the commander of the port. Then, in a pouring rain, he climbed into a carriage and set out for home. All night, cramped in the carriage and trying to sleep on the hard, bouncy seat, he rode through the dark to Merton. It was 6 AM, and a gray and cheerless dawn, when he arrived...

At Merton, Nelson could sleep as late as he wanted, while away the lazy hours wandering about the grounds of the estate and forget all the cares of the war at sea, but he was unable to make such a complete change. He still rose in the morning before dawn, and he spent most of his time pacing back and forth at the summerhouse he called 'the poop.' As he paced, he made his plans for attacking the Combined Fleet...

He was wasted and thin from his long service in the Mediterranean. His unseeing right eye and the green shade over the other made it difficult for him to see, and he had to walk slowly and with great care, sometimes stumbling over a curb or barely missing a lamppost. Still, he walked as erect as any officer in the Royal Navy, and one clerk at the Admiralty noticed that in the courtyard Nelson strode straight across the difficult cobblestones to the doorway instead of following the smoother path. In fact, the clerk said, this was what told him right away that the newcomer must be Nelson himself."¹⁰⁴

1805: Battle of Trafalgar— and Death

News came that the Combined

French/Spanish Fleet had been discovered leaving the Spanish port of Cadiz to meet Nelson's in battle.

"The news that Villeneuve 'had come out' reawoke in Nelson all the old prophetic premonitions of death. He discounted the possibility of losing a leg, but contemplated the prospect of losing his life. He would, he announced over dinner, prefer to be buried in St. Paul's rather than Westminster Abbey. The Abbey's foundations lay in marshy ground and his body would soon rot. In the drier soil of St. Paul's, it would last forever."¹⁰⁵

He was right, for the Battle of Trafalgar, Oct. 21, 1805, was to be his last—and his greatest victory. Simply stated, "Nelson was killed by a bullet which traversed his shoulder, lung, pulmonary artery and spinal cord."¹⁰⁶ As stated earlier, the bullet was fired by a French marine from the rigging of the ship **Redoutable**, which was locked in combat with Nelson's flagship, the **Victory**.

There are several detailed accounts of the fatal wounding. States Author Pocock:

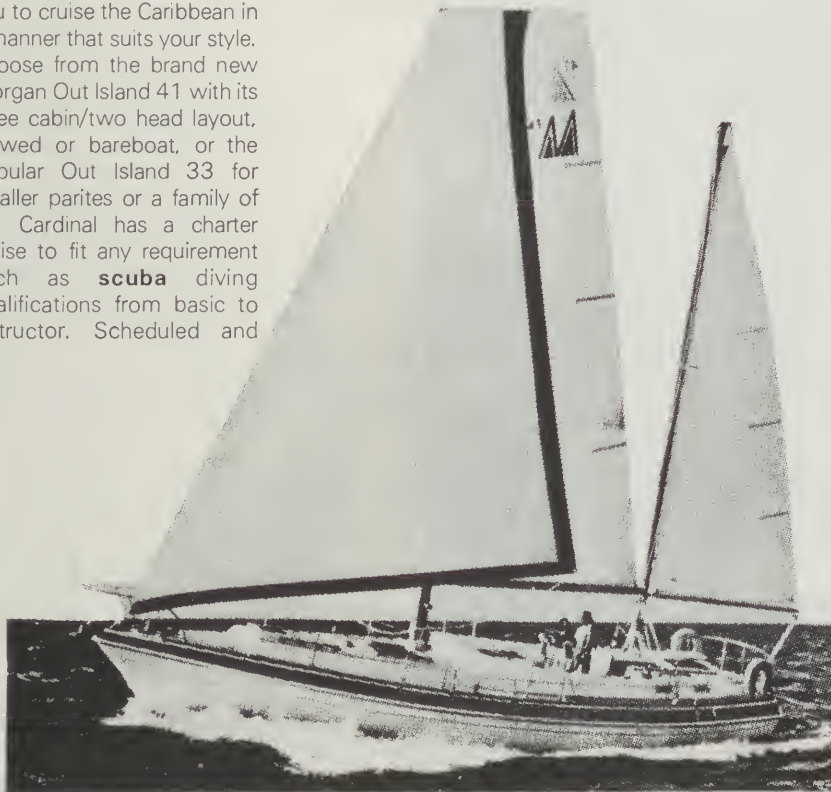
"Nelson and Hardy paced, side by side, on the quarterdeck, concealed from the enemy only by gunsmoke. For half an hour, they had walked thus, when, at their usual

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turning point, Hardy noticed Nelson was not beside him, turned and saw the Admiral on his knees, the fingers of his left hand touching the deck. Then he slipped on to his side. "They have done for me at last, Hardy. My backbone is shot through."

As Nelson was carried below to the surgeon on the orlop deck, he covered his face with his handkerchief so that he would not be recognized. Once below, his clothes were cut off him and Surgeon Beatty quickly saw that nothing could save his life.

A musketball from a French sniper, fired from above, had penetrated Nelson's shoulder and chest and lodged in his spine. Pain and internal bleeding convinced Nelson that he was dying fast. "Remember me to Lady Hamilton! Remember me to Horatia!" He then became calmer and said he would live another half hour. While Beatty and his assistants brought cooling drinks, fanned his face and rubbed his chest to ease the pain, Nelson could hear cheers from the gun decks above, as enemy ships struck their colors, and the whole ship jarred at each broadside.

Hardy visited him with the news that victory was complete and that at least 15 of the enemy had surrendered. "That is well," Nelson muttered, "but I had bargained for 20." He then reminded Hardy to anchor after the battle, and renewed his pleas for the care of Emma. He asked Hardy to kiss him farewell. "Now I am satisfied," he said. "Thank God I have done my duty."

To the Chaplain, he now said, "Doctor, I have not been a great sinner." And "Re-

member, I leave Lady Hamilton and my daughter Horatia as a legacy to my country, and never forget Horatia." (Ed. note—previously, he'd not admitted his paternity of Horatia by Emma Hamilton.—BT.)

As he sank into unconsciousness, he would mutter, "Fan, fan" and "Rub, rub," then was silent. At half-past four on Oct. 21, 1805, nearly three hours after he had been hit, Nelson died.¹⁰⁷

Says Oliver Warner:

"Nelson was carried below to the cockpit by Sgt. Seeker and two seamen. 'They have done for me at last,' he said to his Flag-Captain. 'I hope not,' said Hardy, remembering Nelson's wound at the Nile, which he had thought at first to be mortal. 'Yes,' answered the Admiral, 'my backbone is shot through.' He lived for several hours more, but in great pain, and with the certainty that nothing could be done to save him. Even the conduct of the battle was out of his hands. It was every captain for himself; but Nelson knew well enough he could rely on their success."¹⁰⁸

Dr. Gooddy writes in more strictly medical detail of the wound:

"Penetrating wound of the left shoulder; fracture of two left upper ribs; penetration of left lung; division of branch of left pulmonary artery; fractures of sixth and

seventh dorsal vertebrae; contusion of the spinal cord; Metallic foreign body retained..."

Nelson was carried below to the Surgeon's quarters, which were painted all in red. "It was like a butcher's shambles," said the Rev. Dr. Scott, who stayed with Nelson 'till he died.

Though there have been numerous accounts of the death of Nelson, none has equalled the description of one of the chief eyewitnesses, Dr. William Beatty. He wrote, in 1807, "The Authentic Narrative of the Death of Lord Nelson." This work contains perhaps the best illustration of the fatal bullet, together with the cloth of the uniform and some of the gold bullion of the epaulette which it penetrated.

Dr. Beatty took a history, asking his patient to give him a full account of the occurrence, with all his sensations. Nelson answered that he had no sensation in the lower part of his body, and that he felt 'a gush of blood' every minute within his breast. Respiration was short and difficult, and he felt very acute pain about that part of the spine which he thought had been struck by the ball. 'I felt it break my back,' he said, but his pain was not due to an external injury to the back as was at that time supposed (until Beatty's examination had shown no superficial wound in the back). It was later shown that the bullet had passed into the chest through the left epaulette. In its course, it broke two ribs and severed a main branch of the left pulmonary artery. It then passed on to fracture the sixth and seventh dorsal vertebrae, before ending in the paravertebral muscles. Nelson was complaining of mid-dorsal root pain, from spinal cord damage at that level. The effect of the bullet upon the spine was to cause a transection of the cord. Nelson, therefore, had, and complained of, mid-dorsal root pain, combined with total motor and sensory paraplegia. It was because of spinal cord damage that he had subsided to the deck after wounding. It must be considered a most dramatic symptom of pulmonary artery damage for the patient to describe the gushing of blood within his chest. This severe hemorrhage caused great pallor, a barely perceptible pulse and air hunger. Nelson complained also of great thirst, and was constantly plied with lemonade. A small fan was constructed from paper, and used to fan Nelson in the cramped and crowded lower deck.

The Surgeon already knew, from 'the gush of blood' which his Lordship complained of, together with the state of his pulse, the hopeless situation of his patient.

Nelson kept repeating 'fan, fan,' and 'drink, drink.' This he continued to repeat when he wished for drink or the refreshment of cool air, till a very few minutes before he expired. Lemonade, and wine and water, were given to him occasionally. Mr. Burke told him: 'The enemy were decisively defeated, and that he hoped his Lordship would still live to be himself the bearer of the joyful tidings to his country.'

He replied: 'It is nonsense, Mr. Burke, to suppose that I can live: my sufferings are great, but they will soon be over...'

His Lordship now requested the Surgeon, who had been previously absent a short time attending Mr. Rivers (a midshipman who lost a leg), to return to the



"THE DEATH OF NELSON," from a painting by A. W. Devis, depicts the dying Admiral below decks of his flagship, HMS *Victory*, surrounded by physicians and other officers. His bemedalled uniform jacket—which attracted the fatal rifle-fire of the French marines—lies crumpled at his feet.

wounded and give his assistance to such of them as he could be useful to, 'for', said he, 'you can do nothing for me.'

After the Surgeon had been absent a few minutes, he was called by Dr. Scott to his Lordship, who said: 'Ah, Mr. Beatty! I have sent for you to say, what I forgot to tell you before, that all power of motion and feeling below my breast are gone: and you,' continued he, 'very well know that I can live but a short time.'

The emphatic manner in which he pronounced these last words left no doubt in the Surgeon's mind that he adverted to the case of a man who had some months before received a mortal injury of the spine on board the **Victory**, and had labored under similar privations of sense and muscular motion. The case had made a great impression on Lord Nelson; and he was anxious to know the cause of such symptoms, which was accordingly explained to him and he now appeared to apply the situation and fate of this man to himself.

The Surgeon answered: 'My Lord, you told me so before,' but he now examined the extremities, to ascertain the fact, when his Lordship said: 'Ah, Beatty! I am too certain of it; Scott and Burke have tried it already. You know I am gone.'

The Surgeon replied: 'My Lord, unhappily for our country, nothing can be done for you.' Having made this declaration, he was so much affected that he turned round and withdrew a few steps to conceal his emotion.

His Lordship said: 'I know it. I feel something rising in my breast,' putting his hand on his left side, 'which tells me I am gone.'

Drink was recommended liberally, and Dr. Scott and Mr. Burke fanned him with paper. He often exclaimed: 'God be praised, I have done my duty'; and upon the Surgeon's enquiring whether his pain was still very great, he declared it continued so very severe, that he wished he was dead. 'Yet,' said he in a lower voice, 'one would like to live a little longer, too.'

Capt. Hardy now came to the cockpit to see his Lordship a second time. Lord Nelson and Capt. Hardy shook hands again and while the Capt. retained his Lordship's hand, he congratulated him, even in the arms of death, on his brilliant victory.

He then told Capt. Hardy, he 'felt that in a few minutes he should be no more,' adding in a low tone: 'Don't throw me overboard, Hardy.'

The Captain answered: 'Oh no, certainly not...!'

Lord Nelson died at half-past four in the afternoon, about three hours after the fatal wound was received...¹⁰⁹

Author Terraine points out (in an excellent schematic cutaway diagram of the **Victory**) that Nelson died in the Midshipmen's Berth¹¹⁰ (where, ironically, he'd begun his naval career.)

Whipple relates how, prior to the shooting,

"As Nelson stood watching them, Dr. Beatty approached Capt. Hardy, the **Victory's** Master. Dr. Beatty was worried about

Nelson's safety. The Admiral was wearing the uniform coat he had worn ever since coming aboard the **Victory**. The coat had embroidered decorations on its left breast, and Beatty thought they made too good a target. There were sure to be sharpshooters in the enemy's tops. Beatty asked Hardy if the Admiral shouldn't be asked to change his coat for one that would attract less attention. Hardy answered that he did not think the Admiral would like being told to change his coat, even for a reason like this, but he promised that he would mention it if he got a chance'¹¹¹ Characteristically, Nelson refused.¹¹²

Another such characteristic action, adds Whipple, also helped kill the Admiral; he ordered his own protective squad of British marines, when the enemy fire became intense, to disperse. "Later, the marines could have helped protect him from the sharpshooters in the enemy tops."¹¹³

While Nelson lay, "...drowning in his own blood" (from the punctured lung),¹¹⁴ his marines helped avenge his wounding. As one of them recalled later, in reference to the French marines, "I remained firing till there was not a man to be seen in the top."¹¹⁵

And that was not all. French Rear Adm. Charles Magon was

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killed,¹¹⁶ as were "4,530 sailors and nine ships' captains." The wounded numbered 3,573, among them Rear Adms. Cisneros, Alava and Gravina and 10 ships' captains. Villeneuve was captured, together with several hundreds of the men who served under him. By comparison, British casualties were light—449 men killed and 1,214 wounded. The death toll throughout Nelson's entire fleet was less than the tally of dead in the **Redoutable** alone."¹¹⁷

The Combined Fleet surrendered 18 ships, while the British lost none.¹¹⁸

Epilogue

Nelson's demise soured the news in England of his great victory. "'When Nelson died,' wrote the poet Coleridge, 'it seemed as if no man was a stranger to another: for all were made acquaintance in the rights of common anguish.'"¹¹⁹ His body was taken to Gibraltar and then to England, where his funeral procession left Greenwich Hospital Jan. 8, 1806 (more than **two months** after his death!) to float down the Thames River in London.¹²⁰

The final irony of his career occurred almost a full decade later, in 1815. Napoleon, defeated at last, was carried to his final exile on the island of St. Helena aboard the British warship **Bellerophon**—which had been under Lord Nelson's command at Trafalgar.

Acknowledgments

The author thanks Mrs. Mildred Chronister for secretarial services.

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Do Reindeer Really Fly?

By RICHARD F. CIOFFI, MD and JOLLY OLD ST. NICK, PhD

From the Department of Aerospace Medicine, North Pole Hospital and Medical School.

Introduction

For a number of years, there has been a great deal of controversy regarding the possibility of the reindeer's ability to fly. Some¹⁻² believe that reindeer indeed **can** fly. Direct observation, as well as circumstantial evidence, such as hoof prints in strange places, appears to indicate that at certain times during the winter season, reindeer, usually in groups, have been known to pull a vehicle through the sky and have been known to land on rooftops. Others, however,³ have denied that this is possible and have argued to the contrary, sometimes bitterly.

Because of this controversy, a study was undertaken to determine whether reindeer indeed **can** fly. The purpose of this paper is to present the results of such a study.

Materials and Methods

Seventeen male Canadian reindeer ranging in age from seven to nine years and weighing between 300 and 500 kg. were studied. All were kept in my backyard and attended to by children ranging in ages from three to 11 years. These reindeer were arbitrarily separated into three groups. Group One consisted of eight reindeer maintained on a diet of candy canes and sugar plums. Group Two consisted of eight reindeer fed a standard reindeer chow. Group Three consisted of one reindeer younger than the rest who had the dubious distinction of having a red nose.

Each reindeer, singly, or in a group, was brought to the top of my garage roof and either voluntarily or forcibly jumped from the roof. In another study, the reindeer were paired in groups of two, four, and eight, with and without harnesses and, on more than one

occasion, a sled-like vehicle was attached to the harness. In a separate set of experiments, the reindeer from Group Three was placed at the lead of each group of eight. One of the authors (SC) guided the sled-like vehicle at various times during the study period and would further add weight and stability to the team. On occasion, words such as "Ho, ho!" were uttered by the author arbitrarily.

Results

All the reindeer from Group Two demonstrated an inability to maintain themselves in a flying position either singly or in mixed groups. This was especially likely to occur when the group was harnessed together. During the study period, the reindeer from Group Three, who was asked to lead this team, became so disgusted at their inability to fly that his nose ceased glowing. Even my coauthor became so depressed at their inability to fly



that he was heard to mutter such phrases as "Oh, hell, Christmas will never come."

On the contrary, each reindeer in Group One demonstrated a unique ability to fly. Left on their own, each reindeer was able to fly approximately 12 miles and land gingerly again on top of the roof of my house. There was a strange predilection to land as close to the chimney as possible and this cannot be explained. When the reindeer were paired in groups of two, four, six and, finally, eight, not only flight time but flight distance was increased. Furthermore, their landing pattern was quite unique in that they would land in unison and quite smoothly on the roof. At no time did any reindeer slip or tend to veer from his designated course. When all eight reindeer were together, and when leading the sled-like vehicle with the coauthor in control, a distance of some 120 miles was covered during one flight. Indeed, during one of the night flights in the midst of a dense fog, the reindeer from Group Three demonstrated the uncanny ability to lead the group up to 240 miles. When this had been ac-

complished, my coauthor was heard to exclaim a phrase which ended "...and to all a good night!"

Conclusion

This study demonstrates that under the right set of circumstances, there is a group of reindeer that has clearly demonstrated the ability to fly for rather long distances and, further, has demonstrated the ability to pull a sled-like vehicle with a passenger. For reasons not entirely explained, the reindeer had to be fed a special diet and, further, demonstrated the uncanny tendency to land as close to a chimney as possible; however, it was further apparent during this study that a certain combination of reindeer had to fly together in order to achieve the most distance. For example, a reindeer by the name of Dasher had to fly next to a reindeer named Dancer, so also Cupid and Comet and Donner and Blitzen had to fly in pairs. Another unanswered question is why the single reindeer in Group Three, while rejected by the other reindeer at ground level, seemed to be accepted by the group as leader when he flew in the lead position.

Other unanswered questions from the study are what's to be done with 20 pounds of deer dung and what to do with the 17 scrawny reindeer that are still in my back yard?

SEASONS GREETINGS!

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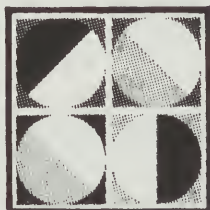
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Drinking and Driving in Maryland: A Special Report, 1979

By CAROL BENNER, BA; DEL. TORREY C. BROWN, MD and R ADAMS COWLEY, MD

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ABSTRACT

Drinking alcohol and driving is a critical problem in Maryland. One half of all traffic fatalities, serious injury highway accidents and unknown numbers of minor accidents and traffic violations are directly attributable to drinking and driving. Driving is a privilege granted to the citizen by the State. As a condition of maintaining the privilege, the driver must abide by certain conditions legislated and enforced by the State. A major dilemma in Maryland has been how to identify the drinking driver, rehabilitate him/her and ultimately make the highways as safe as possible.

This paper examines the problem in Maryland. Basic principles of blood alcohol content and risk of accident, serious injury and death due to vehicular cause are presented with pertinent Maryland data. A description of the present law is provided with discussion of the strengths and weaknesses. A final section discusses the alternatives and the salient issues that the State needs to address.

Blood Alcohol Content (BAC)

The Blood Alcohol Content (BAC) is the universal legal standard for determining intoxication. It is defined as the percentage (weight by volume) of ethyl alcohol in the blood. Various factors affect the BAC and include a) the number and strength of drinks consumed, b) the interval of drinking, c) the amount of food consumed and d) body weight. Because of the variability of these factors and the variability of the metabolism of alcohol in individuals, it is not possible to compare amounts of alcohol consumed when discussing effects of impairment or intoxication.

For example, a 200-pound person will metabolize alcohol quicker than a 150-pound person; an "old topper" or experienced drinker will metabolize alcohol quicker than the uninitiated or inexperienced drinker.

There is, however, only a very small difference in the response of individuals to a given level of alcohol circulating in the blood. Muehlberger states that "All men with the same blood alcohol level (BAC) are approximately equally intoxicated within an error plus or minus of 10 or 15%."¹ Thus, even though it may take significantly different amounts of alcohol to reach a BAC of .10%, all persons at this level are about equally affected.

Table 1 indicates approximate amounts of alcohol for individuals at two different body weights needed to attain specific blood alcohol levels.²⁻⁴

The BAC and Risk of Accident, Serious Injury and Death on the Highway

The physiological effects of alcohol on the body are well documented. Alcohol is a depressant and causes decrease of inhibitions, lack of muscular coordination, resistance to stimuli, confusion, slurring speech, staggering and so forth.

Sufficient dysfunction to impede careful operation of an automobile occurs at the .10% blood alcohol level. If, at a BAC of 0.0% the risk factor is one, the probability of crash increases four times at .08%, seven times at .10%, 25 times at .15%, 60 times at .18% and 100 times at .20%.⁵⁻⁶

Actual data that demonstrates the correlation between BAC and death or serious injury due to vehicular accident is more striking. The Maryland State Medical Examiner's Office reports that in 1977, 693 persons died on Maryland highways. Of the 509 pedestrians and drivers, 319 (63%) had detectable alcohol levels with the average well above .10%. A special unreleased report shows that 80% of the drivers who were considered at-fault had been drinking.⁷

Information concerning BAC and serious injury accident is also available. The Maryland Institute for Emergency Medical Services (Shock Trauma Unit) is a specialty referral unit for seriously injured victims. The Institute provides information concerning blood alcohol levels on 598 automobile accident victims admitted in 1977 and 1978 (See Table 2). Comparison of the MIEMSS population to a national roadside survey of all drivers⁵ shows a gross over-representation in the high BAC classification: 39% of admissions above .10% compared to up to 2.0% of all drivers and 24% above .15% compared to 1.0%. The average BAC of the victims was .144%.⁸ (In a national roadside survey, drivers are randomly stopped and examined for blood alcohol content. During the daytime hours, about 10% of all drivers have been drinking; in the evening and nighttime hours, about 20% of all drivers have been drinking.)

Thus, it appears that the available Maryland data confirms national statistics: that alcohol is contributory to serious injury accidents and highway related death, and the majority of these tragedies occur at a BAC of .10% and higher.

Table 1:
Approximate Blood Alcohol as a Function of Body Weight and Alcohol Consumed

Body Weight	Number of Drinks* To Reach .10%	Number of Drinks To Reach .15%
120 lbs.	3	5
150 lbs.	4.5	6.5
180 lbs.	6	8

*One drink is equivalent to one 12-ounce beer, one five ounce glass of wine or one and one-half ounce of 86 proof distilled spirits.

The Maryland Law for Drinking and Driving

In 1969, the Maryland General Assembly changed the drinking and driving laws to include 1) an express consent statute relating to the chemical test for alcohol content, and 2) a two-step system for prosecuting offenders for driving while under the influence of alcohol.

The express consent provision is consistent with laws in other states. The Transportation Article (MD Transp. Code Ann. § 16.205.1) attempts to insure that a chemical test (breath or blood) is administered to an individual if he/she is detained by a police officer for suspicion of operating or attempting to operate an automobile while under the influence of alcohol. As a condition of receiving a license to drive, the individual must sign a pledge consenting to the test if requested. Notwithstanding this pledge, however, the individual cannot be compelled to take the test; however, refusal can lead to loss of driving privileges for a period of up to 60 days.

Although refusal to take the test cannot lead to an inference of guilt or innocence, results from the test are admissible as evidence, **Schmerber v. CA, 384 US 757 (1966); Major v. MD, 31 MD App. 590 (1976)**. At a BAC between .05% and .10%, no presumption of intoxication or impairment can be made. At a blood alcohol level of .10% and above, there is evidence of impairment; and at .15% and above, there is prima facie evidence of intoxication (MD Cts. and Jud. Proc. Code Ann. §§ 10.302 to 10.309).

The second provision of the law (MD Transp. Code Ann. §§ 21-902) provides a two-standard system for prosecution: a) driving while intoxicated at .15% and above, and b) driving while impaired at .10% and above; 48 other states have a single standard system for driving while intoxicated at a minimum of .10% blood alcohol level. (New Jersey changed its statute in 1977 to .10%. Mississippi has a statute similar to Maryland. Utah and Idaho have driving while intoxicated levels at .08%). It is interesting to note that the US Department of Transportation recommends a driving while intoxicated statute at .10% BAC.⁶

The law carries both judicial and administrative sanctions. The judicial penalties include jail terms and fines; the administrative sanctions are imposed after a hearing by the Motor Vehicle Administration (MVA) and include suspension or revocation of the privilege to

drive.

One conviction of driving while intoxicated or three convictions in three years for driving while impaired can lead to revocation (formal termination of a person's license to drive). One conviction for driving while impaired can lead to a 60-day suspension (temporary withdrawal of the driver's license) and two convictions for driving while impaired in three years can lead to a 120-day suspension (MD Transp. Code Ann. § 16.205).

There are other recommendations that either the Court or MVA can suggest. These are primarily concerned with rehabilitation and education of the drinking driver and include referral to a driver's rehabilitation clinic, alcohol education program or to the MVA's Medical Advisory Board. These final sanctions are not exclusive of the administrative sanctions and can be imposed simultaneously with them.

With the inception of the chemical test for alcohol content in 1969, the numbers of arrests and convictions for drinking and driving increased dramatically.⁹ No doubt both the police and judicial system felt the strong and powerful effect of the blood alcohol test as supportive and conclusive evidence; however, review of police statistics demonstrates the complexity and difficulty with the express consent statute. The MVA licenses about two million drivers in Maryland. The Maryland city, county and state police forces arrested about 13,000 persons for driving under the influence of alcohol in 1977 and in 1978 or approximately six drivers per thousand. In 1973, the Alcohol Safety Action Program, a Federally-funded safe driving effort, reported six drinking and driving arrests per thousand drivers in the Baltimore area with some areas of the country as high as 35 per thousand.¹⁰ Thus, although there may have been an immediate impact of the new law felt in 1970, the arrest rate has remained low when compared to other areas of the nation.

Furthermore, of the 13,000 persons arrested for driving under the influence, 39% refused to take the chemical test. (See Table 3.) Although this group is subject to license suspension, the probability of conviction for driving while intoxicated or impaired is lessened without the presumptive or prima facie evidence.

It has been suggested that some drinking drivers refuse to take the test as a ploy to avoid conviction. Refusal cannot be used as evidence against the defendant, nor can it count as an alcohol related vehicle of-

Table 2:
Comparison of Blood Alcohol Content in Serious Injury Accident Victims in MIEMSS Population (1977-78)
to the Blood Alcohol Content in a National Roadside Survey of the Total Driving Population

	Negative	.001-.049%	.050-.099%	.100-.149%	≥.150%
MIEMSS Auto Accident Population (N=598 100%)	297 (50%)	11 (2%)	55 (9%)	91 (15%)	144 (24%)
Total Driving Population	80%-90%	5%-10%	5%	2%	up to 1.0%

Table 3:
Blood Alcohol Content in Persons Arrested for Driving Under the Influence in 1977-78

	Number Arrested	Refused Test	.001-.049%	.050-.099%	.100-.149%	≥.150%
1977	13,223 (100%)	5031 (38%)	424 (3%)	398 (3%)	1370 (10%)	5781 (44%)
1978	13,129 (100%)	4976 (38%)	362 (3%)	400 (3%)	1307 (10%)	5860 (45%)

fense. (Refusal with administrative sanction, is however, noted on the driving record).

Even so, the use of the PBJ (probation before judgment) rather than an explicit finding of guilt or innocence is common. (A PBJ is a disposition by the court. The PBJ carries an implication, of guilt, but is **not** a guilty finding. The number of PBJs in Maryland is unknown.) A frequent condition of the PBJ is successful completion of an alcohol rehabilitation program. This allows the offender to maintain his driving license while resolving his drinking problem. Again, the ambivalence of judges and/or prosecutors emerges concerning suspension or revocation, the ultimate consequence of conviction. Unfortunately, there has been no effective evaluation of the rehabilitation efforts to indicate success or failure. A national study of community alcohol related programs indicated that, in fact, the programs may have no deterring effect for future violations and may cause adverse effects.¹¹ Evaluation of the programs is difficult because offenders undergoing rehabilitation usually keep their licenses, whereas convicted persons usually have their licenses suspended.

When discussing the Maryland law, a question always arises concerning the leniency of penalty compared to other states. If consideration is given to the .10% conviction and subsequent sanction, the following is observed:

1) About 60% of the states have at least a minimum license suspension for 30 days at the .10% level. Some of the states have a minimum one-year revocation.

2) About 30% of the states have a minimum sanction of license suspension, but will substitute a restricted or limited license if appropriate.

3) Only four states (Maryland, Mississippi, Nevada, Washington) have no minimum sanction.

4) The maximum penalty in Maryland at the .15% level (revocation) seems to compare equivocally with the maximum penalties of other states at the .10% (in most states, suspension from six months to revocation).¹²

Analysis of enforcement of laws is another matter. Numbers of convictions for driving while intoxicated or driving while impaired are unknown in Maryland, much less in other states. It is difficult to compare effectiveness and outcomes of laws without these data.

Alternatives, Conclusion

Alternatives that have been suggested for Maryland include 1) mandatory administration sanctions for driving while impaired or intoxicated, and 2) lowering the limits of BAC from .10% and .15% to .08% and .10% for driving while impaired and driving while intoxicated. The mandatory penalties remove discretionary power from the judicial system, and the lowering of legal limits changes the Maryland law from what superficially appears to be very liberal to very strict. Both alternatives have met with opposition in the Maryland General Assembly (HB 747, 1979; SB 74, 1979). A more effective attempt may be to eliminate the two standard system and adopt the .10% BAC limit for driving while intoxicated similar to 46 other states.

A third alternative takes a different approach and targets the offender who refuses to take the chemical test and hence provide conclusive evidence for prosecution. This solution suggests increasing the time of

license suspension for refusal to take the test. It is interesting to note that the California statute (CA Veh. Code § 13353 (West)) suspends licenses for six months for refusal to take the test¹³ and the New York statute (NY Veh. and Traf. Law § 1194 (McKinney)) revokes licenses for a similar offense.¹⁴ (Both of these laws include hearings if requested by the offender before a motor vehicle administration.) The rationale behind this suggests that police officers will identify more drinking drivers if the presumptive or prima facie evidence is available for possible conviction.

In summary, it seems that, in Maryland, there is substantial evidence to support the presence of a drinking and driving problem, but insufficient evidence to evaluate the present legal process. Four salient issues need to be addressed in the state:

1) The lower number of arrests for driving under the influence as compared to other states;

2) The high proportion of persons who refuse to take the blood alcohol test when requested;

3) The high legal limit for driving while intoxicated (.15%) compared to recommendations by the Department of Transportation (.10%) and

4) The effectiveness of rehabilitation measures.

More importantly, the issue of whether the drunken driver should or should not be taken off the highway needs to be resolved. Then an effective system of identification of offenders can be developed and rehabilitative programs and the enforcement of laws can be active programs in this state.

Acknowledgments

I thank the following for their support and assistance: State Sen. Rosalie S. Abrams and Del. Joseph Owens from the Maryland Legislature, William Clark from the Maryland State Police, Judge Robert Sweeney from the Maryland District Court, Dennis Evans from the State Highway Coordinating Committee, Dr. Geoffrey Gibson and Dr. Carl Schramm from the Johns Hopkins University School of Hygiene and Public Health, Ms. Marianna Herschel and Dr. Roy Myers from the Maryland Institute for Emergency Medical Services System and Ms. Dottie McCaleb and Ms. Yvonne Summers for their technical assistance.

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Medical Miscellany

A Note From the Telephone Co....

Most people at one time or another have taken a First Aid course, but, to paraphrase the late Vince Lombardi, "...Everyone can use a little more instruction in the basics."

To help with the "basics" in saving a person's life, residents of Baltimore can now turn to their **Yellow Pages** directories. Contained in the front of the new directory is an eight-page Emergency Medical Guide, prepared as a public service by the C and P Telephone Co. of Maryland in cooperation with the Maryland Institute for Emergency Medical Services.

The guide begins with instructions on how to call for professional

help and how to check for breathing. Subsequent information is arranged alphabetically according to the type of medical emergency.

Some of the topics covered include allergic reactions, amputations, poisoning, burns, broken bones, drowning, electric shock and seizures.

C and P is the second Bell System company to carry medical information in a directory. Pacific Telephone was the first, with a section in its San Francisco directory.

While the guide is not intended to take the place of formal training or professional assistance, it does provide concise information about the "basics" of First Aid.

Psychiatric Admission

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Endometrial Extension of Cervical Tumor: A New Technique for Definitive Detection

By HERBERT L. KOTZ, MD

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Abstract

A new technique is described which permits accurate information on the presence or absence of endometrial extension from cervical cancer. The clinical importance of the technique is noted.

Introduction

While endometrial extension of cervical cancer is well recognized,¹⁻³ such cases are included under current FIGO staging as a cervical primary.⁴⁻⁵ A recent paper by Perez, et al⁶ revealed a poorer prognosis as well as a significantly greater incidence of distant metastases in patients with Stage 1 and 2 cervical cancer with endometrial extension. Because of their findings, these authors suggested a modification of therapy may be indicated when endometrial extension has been proven.

Perez, et al⁶ described the difficulty in accurately identifying those cases in which extension occurred and the problems involved in separating these cases from those where the curettings may have been contaminated by the cervical tumor.

They had to separate their cases into four categories: 1) Definite endometrial extension (24 cases—8%). Endometrial stroma and glands were present in the curettings and there was clear evidence of invasion of endometrial stroma by tumor cells. 2) Tumor only (32 cases—10.6%). The curettings contained only epidermoid carcinoma and its supporting stroma. No endometrial glands were present. 3) Admixture of carcinoma and endometrium (46 cases—15.2%). The curettings showed fragments of tumor, with or without supporting stroma, scattered among other fragments of endometrial glands and stroma. No actual tumor invasion of the endometrial fragments could be demonstrated. 4) Negative D and C (200 cases 66.6%).

Since a significant difference in absolute five-year cure rate in Stage 1 between those with proven endometrial extension (50%) and those with negative D and Cs (85%) was found, it would seem that a diagnostic method capable of placing the 25.8% of patients in the second and third categories (inconclusive as to endometrial involvement) would be of value.

The difficulty in accurate determination of endometrial extension from cervical tumors has been well described in the article by Perez, et al.⁶ It is very difficult for the surgeon to be certain that the uterine curettings are not contaminated by the cervical cancer, particularly if there is a significant endocervical component. If it is difficult for the surgeon, the determination of the source of the malignant curettings is **impossible** for the pathologist unless there is clear invasion of the endometrial glands and stroma by the tumor.

The purpose of this communication is to present a simple technique that will accurately identify endometrial extension.

Technique

After cervical biopsies have been obtained and an endocervical curettage performed (if indicated), a small graduated (four or six mm.) plastic, smooth-tipped curette (Vacutage, Warner Chilcott) is introduced into the endometrial cavity, the depth of which is noted. The curette is then attached to suction and curettage of the fundus performed without withdrawing the opening of the curette to the level of the cervix. The suction apparatus is then separated from the cannula and its contents sent for pathologic examination. The cannula is then removed.

Comments

This technique avoids contamination of the curettage specimen with cervical and endocervical tumor making it possible to include almost all patients with Stage 1 and 2 cervical cancers in one of two categories—those with and those without endometrial extension. A third indeterminate category (25.8% in Perez et al's series) is thereby avoided. If additional studies substantiate the clinical significance of endometrial extension, then the use of the technique herein described will permit not only the exact delineation of extent of disease, but a more accurate application of optimum therapy.

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A Family Cluster of Tuberculosis

By J.P.G. FLYNN, MD, MPH; C. R. LAYTON, JR., MD and W. H. MITCHELL, BA

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A 27-year-old white male presented to a community hospital in rural Maryland in June, 1978 with right upper and right mid-chest pain.

His illness started approximately six weeks earlier with symptoms of easy fatigueability, minimal cough, productive of yellowish sputum and increasing shortness of breath with normal exertion. His weight decreased from 150 to 137 pounds.

Pertinent clinical findings were a pale, asthenic male, with soft, non-tender quarter centimeter lymph nodes palpable bilaterally in the anterior cervical chain. Late inspiratory crackles were detected over the right upper chest and the supra-scapular region. Blood pressure was 100/60 and was 20/20 vision.

Sputum smears were positive for acid fast organisms on four occasions. He was initially treated with INH 300 mgs. a day, Ethambutol 15 milligrams per kilogram, and Streptomycin one gram a day intramuscularly. The use of Streptomycin was to insure close contact and supervision of the patient during the first three months of therapy.

Following eight weeks of therapy, his sputum was free of acid-fast organisms; however, cultures sent in September were still found to be positive and did not clear until December, 1978.

In September, Streptomycin was discontinued and Rifampin at 600 milligrams a day started.

Contact investigation was initiated immediately after the case was identified. His 22-year-old wife was found to have a positive PPD, and an elliptical 15 by 15 millimeter-shaped density in the periphery of the right upper lung field. She had a cough of five days' duration productive of greenish sputum. Her smear was negative for acid-fast organisms. She was started on INH 300 milligrams and Ethambutol 15 milligrams per kilogram daily.

Cultures obtained at this time grew out *Mycobacterium tuberculosis*.

Their eight month-old son had been admitted to a community hospital three months previously with a history of a cough, poor fluid intake, tachypnea, vomiting and loose stools, and was found to have a right-sided broncho-pneumonia that cleared with Ampicillin.

When evaluated on the same day as his mother, he was found to have a cough of five days, and diminished nutritional intake. PPD (Mantoux Test) carried out more than 72 hours previously showed no reaction.

Chest X-ray showed right hilar adenopathy and alveolar infiltrates in both lung fields.

Despite the findings of the negative tuberculin test, the family history and clinical findings combined with the chest X-ray pointed directly to a diagnosis of pulmonary tuberculosis in the infant.

He was admitted to a hospital in Baltimore and underwent extensive evaluation that included a negative tracheal aspiration and lumbar puncture.

Repeated tuberculin skin tests were negative. He was started on INH 35 milligrams b.i.d. Streptomycin 140 milligrams injected into the anterior compartment of his thigh by tuberculin syringe and PAS 300 milligrams t.i.d. orally. The patient was subsequently discharged after making excellent progress and gaining 12 ounces during a two-week period. Following discharge, a gastric aspirate grew out *Mycobacterium tuberculosis*.

Ninety persons were identified as contacts in the community or workplace, and after careful tuberculin testing, only nine were found to be positive.

The clinical and epidemiological situations described here raise a number of important points that are worthwhile discussing in more detail.

1) While tuberculosis is predominately a disease of older persons, it is not confined exclusively to any one age group.¹

2) Household contacts to smear positive TB cases are at high risk of infection and development of disease.² Non-household contacts are at a lower risk, particularly to smear negative cases. Priorities for conducting the evaluation of contacts are well-established;³ they are often not adhered to, because of the anxiety TB still provokes within a community.

3) Negative tuberculin tests have been demonstrated in the presence of TB Disease in the past⁴ and, therefore, it is important to obtain a chest X-ray as well as performing a Mantoux Test when close contacts are identified.⁴

4) The major emphasis in TB control is to establish a diagnosis as rapidly as possible, initiate appropriate therapy and insure contact investigation is carried out. The outcome of these efforts are not always as satisfactory as one would desire. Particular attention must be paid to the social needs of the patient and family.

Anxiety still exists concerning the use of INH preventive therapy; however, reports from a number of sources indicate side effects can be prevented with careful patient selection appropriate monitoring,⁶⁻⁷ and protection from TB disease is again confirmed.⁸

The following is a list in order of priority of individuals that should be considered for Isoniazid preventive therapy.

1. Close contacts of a case of TB, particularly smear positive TB cases, (irrespective of tuberculin status).
2. Persons with positive tuberculin tests with ab-

normal chest X-ray findings consistent with non-progressive TB lesions. It is important to exclude bacteriologically positive disease and a prior course of adequate therapy in these persons.

3. Newly infected persons, particularly recent converters, i.e., those that have increased their tuberculin reaction by six millimeters of induration from under 10 millimeters to cover 10 millimeters of induration within a two-year period.

4. Individuals with positive tuberculin skin tests with associated special clinical situations. Particular attention should be paid to those on prolonged therapy with adreno-corticosteroids, immunosuppressive therapy and such conditions as Hodgkins Disease and other reticuloendothelial diseases, silicosis, diabetes mellitus and persons with a history of gastrectomy.

5. Other positive skin test reactors. The risk of TB is highest in infancy, high again in adolescence and early adult life and continues at a lower rate for life time.⁹

Individuals over the age of 35 years should not be considered for INH preventive therapy unless one of the first four risk factors enumerated above are present, notwithstanding the fact that the individual is at lifelong risk of developing TB; however, the risk of hepatitis after the age of 35 is greater and INH should not be used routinely in this group.⁹

At the present moment, the only effective drug we use in preventive therapy is INH (Isoniazid). The standard adult dose is 300 milligrams orally in a single tablet daily. For children, a dose of 10 milligrams per kilogram up to a total of 300 milligrams a day is recommended. The duration of therapy is 12 months.⁹

Therapy should be individualized, carefully reviewed and evaluated by the health care delivery team. It should be stressed to persons that they are embarking on a course of preventive therapy, and they should be part of the decision-making process. From the moment of initial contact with the health care delivery team, the respective recipient must be made to feel at ease, be motivated and encouraged to question each therapeutic step. It is most important to rule out bacteriologically positive or progressive TB disease, prior adequate course of the drug and contraindications to the administration of INH preventive therapy, such as INH-associated liver disease, severe adverse reactions to INH and acute liver disease.⁹

Preventive therapy is not contraindicated, but special attention is indicated by the following:

- a) concurrent use of any other medication on a long-term basis, to exclude drug interaction,
- b) use of diphenylhydantoin (this may have to be reduced to avoid toxicity),
- c) daily use of alcohol which may be associated with a higher incidence of INH hepatitis,
- d) prior use of INH which was discontinued because of side effects,
- e) possibility of current chronic liver disease,
- f) the pregnant patient.⁹

In the latter individual, it is prudent to prescribe only therapeutically necessary medications during pregnancy. It is worthwhile emphasizing that the increased risk of developing TB for a new mother is

during the post-partum period.⁹

It is most important to have a system for maintaining records and for monitoring and motivating the patient. Only one month's supply of drug should be provided to the patient at a time. The patient should be aware of and encouraged to communicate any untoward effects or any apprehensions they may have while taking INH.⁹

The Division of Respiratory Diseases in the State of Maryland Department of Health and Mental Hygiene developed a uniform document for use throughout the State to screen patients prior to initiation of preventive therapy and monitor at monthly intervals for adverse reactions and side-effects. Analysis of data generated from the standard chemoprophylaxis record indicates an increase since 1972 in the number of individuals taking Isoniazid for preventive therapy; however, there is still concern that infected persons at greatest risk are not starting on preventive therapy and those who are starting may be discontinuing the drug prematurely. On an encouraging note, it should be emphasized that in recent years in Maryland there were fewer individuals with serious liver problems compared to that observed in other study populations.¹⁰

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Acknowledgments

The authors thank the following: Ms. P. Davis, CHN, Wicomico County Health Department and Ms. Eleanore Farace for preparation of the manuscript. □

Coming in the Journal:

Symptomatic Splenic Secondary Cyst: A Case Report and Review of Literature, by Yu-Wan Chang, MD

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Dec. 7, 1-4:15 PM, Understanding and Treating Sexual Impotence, Paul Fink, MD. (Philadelphia), 3 hrs., Cat. 1 cred.

Dec. 19, 8-10 PM, Endorphins: The Brain's Own Morphine, Solomon Snyder, MD. (Baltimore, Maryland), 2 hrs., Cat. 1 cred.

Jan. 9, 8-10 PM, Approaches to an Understanding of Delinquency; spkr.: Jos. Noshysitz, MD. Two hrs Cat. 1 cred.

Jan. 18, 1-4:15 PM, Stages in Adult Development; spkr.: Robt. Gould, MD. Three hrs. Cat. 1 cred.

The Johns Hopkins Medical Institutions

Listings are in date(s), title and hours sequence; all courses at the Turner Auditorium Building unless otherwise indicated. For details, call Dr. Janet Hardy at (301) 955-5880.

Feb. 4-8, Topics in Emerg. Med.

Feb. 14-16, Cardiopulmonary Nuc. Med. 1980: Controversies in Nuc. Cardiology.

Feb. 18-25, Current Concepts in Ophthalmology.

Feb. 21-22, Psycho. Assessment (Cat. A. cred.—Psychol-

ogists.)

Feb. 23-28, Update in OB/GYN, 1980.

Feb. 24-26, Ped. Approach to Common Neurological Problems.

University of Maryland School of Medicine

Dec. 7-8, Symp. on Gynecologic Oncology, Internatl. Hotel, BWI Airport. For details, call (301) 528-3956.

Pathobiology and Management of Neoplastic Diseases, The Maryland Cancer Program/University of Maryland, 1979-80, Saturdays, 11:15 AM-1 PM, Univ. of MD Hosp., Rm. 1-704, 22 S. Greene St., Balto, MD. Moderators: Benjamin F. Trump, MD; Peter H. Wiernik, MD, John C. Sutherland, MD and Michael M. Lipsky, PhD. **A Course Designed for Health Professionals of All Disciplines** to provide a forum for the exchange of cancer information, both State and local, at the University of Maryland. All health professionals are encouraged to attend one, several or all sessions.

Dec. 8, Transformation and Neoplastic Process. Spkr.: Cecil Fox, affiliated with Armed Forces Institute of Path. Lab. of Biochem.—NCI and Karolinska Inst., Stockholm.

Dec. 15, Influence of Nutritional Status on Chem. Ca. Spkr.: Frederick C. Kauffman, PhD, affiliated w/Pharm. and Exper. Ther., Univ. of MD Sch. of Med.

Credit is available in the following categories: AMA Cat. I Cont. Educ.; Med. Sch. Elective Cred.; Grad. Cred. Further info. is available by contacting Mrs. Sharon Fiorilli or Mrs. Helene Hess at (301) 528-7075 or 7072.

Feb. 21-March 27, Selected Topics in Family Practice, (Thursdays 5:15 - 7:45 PM) Univ. of MD Sch. of Med. campus. For further info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

March 6-8, 5th An. Symposium on Advances in Cancer Treatment Research, Cross Keys Inn, Balto., MD. For further info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

March 8, Gastroenterology Update, Easton, MD. Contact Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

March 28-29, Assessment and Management of Common Behavior Disorders of Childhood and Adolescence, Annapolis Hilton, MD. For further info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

Apr. 12, Med.—Legal Symposium for Practicing Psychiatrists, Balto., MD. For further info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

Apr. 24-25, Symposium on Autotransfusion, Balto., MD. For additional info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

May 6, Pediatric Ophthalmology, Balto., MD. For additional info. contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

June 1-7, 6th An. Family Med. Review Course, Annapolis Hilton, MD. For additional info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956.

June 9-13 and June 16-20, Diag. Electromicroscopy: The Cell Biology of Disease, Balto., MD. For additional info., contact the Prog. of Cont. Educ., Univ. of MD Sch. of Med. at (301) 528-3956. □

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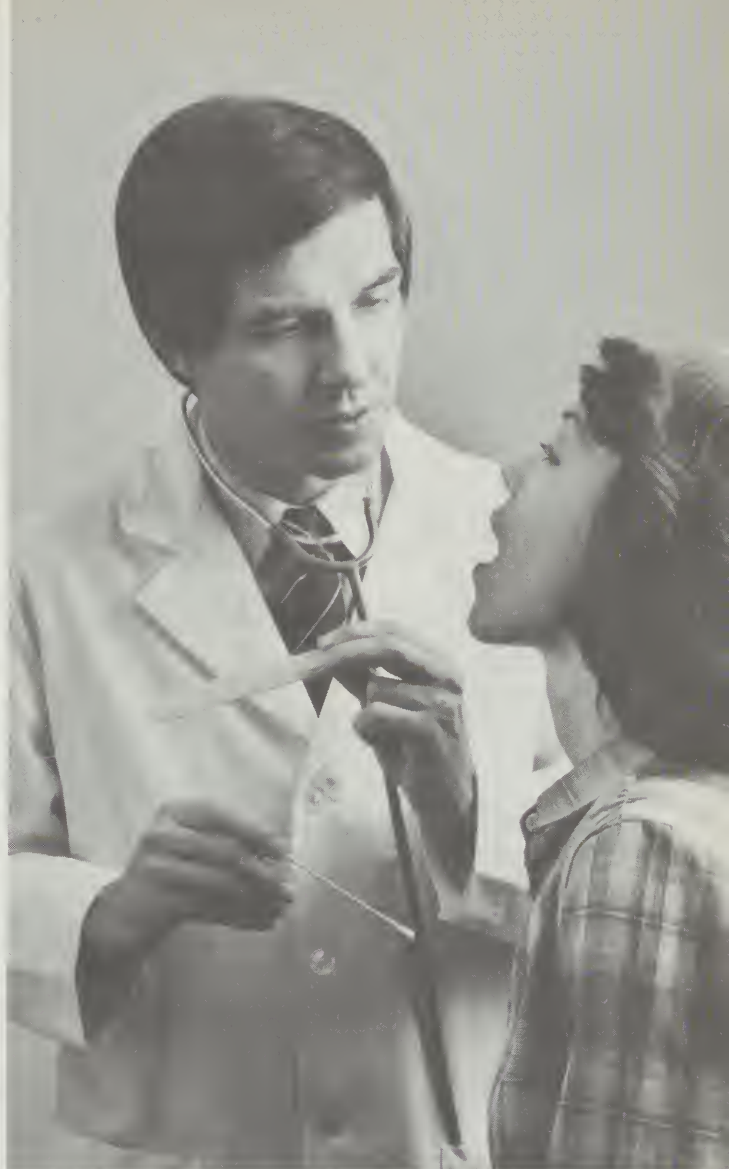


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Medical Miscellany

Annual Prize in Honor of Dr. Wendell Muncie

The Maryland Association of Private Practicing Psychiatrists and The Maryland Psychiatric Society jointly announce a contest for the awarding of a \$300 Prize, which will be made to the author who submits the best paper pertaining to a psychiatric subject. Eligible to enter are physicians who reside or practice within the bounds of the Maryland District Branch of The American Psychiatric Association, (i.e., all of Maryland except Prince George's and Montgomery Counties), who, as of the deadline for submission of the paper, are no more than 10 years beyond graduation from medical school, have completed at least one year of an approved psychiatric residency and are currently active in the profession of psychiatry.

The subject matter is broadly any topic pertaining to psychiatry or allied fields, and may be of clinical, research, theoretical or other aspects of the subject. The paper must be unpublished and there are no restrictions as to length.

All manuscripts must be received by Dec. 15, 1979. They should be mailed to Douglas A. Puryear, MD, Committee Chairperson, The Wendell Muncie Annual Prize Award, 1204 Maryland Ave., Balto., MD 21201.

The winner will be asked to read the paper personally at the joint meeting of the two societies scheduled for March 6, 1980.

1980 Achievement Award Competition

The American Psychiatric Association Hospital and Community Psychiatry Service advises that each year the Achievement Awards Board of the American Psychiatric Association solicits applications for awards by psychiatric programs of original quality or exceptional merit. With the support of the District Branches, the winners are selected annually. Appropriately-incrased plaques are awarded to the winners at the APA Institute on Hospital and Community Psychiatry.

While national recognition goes to the winners, psychiatry in general also benefits. New ideas and techniques are publicized, shared and retested under other conditions until many of them become standard practice.

The Board has always been concerned that some project of great potential value may be missed because no application is made. We are therefore appealing to every District Branch and to every State Mental Health Director to encourage worthy applicants from their areas. Any legitimate program benefiting the mentally-ill or retarded is eligible, whether it is based in a school, clinic or the community.

A special section of the October, 1979 issue of Hospital and Community Psychiatry is devoted to the 1980 award winning programs, and it is hoped you will be stimulated to think about new programs and develop-

ments in your local mental health facilities and be able to persuade them to enter the 1980 competition.

Applications must be postmarked before January 15, 1980. Applications and instructions for entering the 1980 competition are available through the Maryland Psychiatric Society's office at (301) 752-8292.

AMA Publishes New Register

Over 2,600 practice opportunities for physicians are listed in the August, 1979 edition of the **Opportunity Placement Register** published quarterly by the American Medical Association Physician's Placement Service.

A new "Placement Resources" section has been added with this register, says Leanne P. Irish, Director of the Placement Service.

This new section will list the many formal and informal organizations involved in regular and recurring physician recruitment activities, such as state medical societies, medical specialty societies, State and Federal government organizations, hospital and clinic management corporations, HMOs, large medical facilities and others.

The AMA's Physicians' Placement Service has been working since 1947 to assist physicians in locating new professional positions. The new quarterly placement register has increased the Placement Service's capability to assist the medical community and thereby improve accessibility of health care in the US.

For a copy of the current **Opportunity Placement Register** and registration information, write to: Physicians' Placement Service, AMA, 535 Dearborn St., Chicago, IL 60610.

Physicians from the People's Republic of China Tour Franklin Square Hospital

An eight-member delegation of physicians from the People's Republic of China toured Franklin Square Hospital recently as part of a 20-day visit to the United States in which they will exchange scientific knowledge of the diseases of the elderly.

William Reichel, MD, President of the American Geriatrics Society and Chairman of the Department of Family Practice at Franklin Square, and **Sanford Kotzen**, Executive Director and **D. Thomas Crawford**, MD, Director of Medical Education, hosted the visitors at Franklin Square, the only community hospital the study group will tour.

Presentations were made by **Gerald Glowacki**, MD, Chairman of the Department of Obstetrics and Gynecology; **Kenneth Lewis**, MD, Chairman of the Department of Medicine; Dr. Reichel, Chairman of the Department of Family Practice and **Philip Ferris**, MD, Chairman of the Department of Surgery.

The delegation was invited by the American Geriatric Society, the Gerontological Society and the American Psychiatric Association.

At Franklin Square, the Chinese leaders in gerontology met with the Clinical Chiefs and toured the various laboratories, the Intensive Care Unit, Coronary Care Unit, the Anesthesiology Department, the Psychiatric Unit, Surgical Suites and the Nursery.

They also toured the Dietary Department and Plant Engineering, areas in which they have a great interest. □

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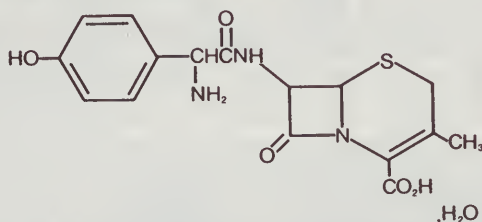
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1. Data on file, Mead Johnson Pharmaceutical Division.
2. Gatley MS: To be taken as directed. *J Roy Coll Gen Pract* 16:39, 1968.

DESCRIPTION: DURICEF® (cefadroxil monohydrate) is a semisynthetic cephalosporin antibiotic intended for oral administration. It is a white to yellowish-white crystalline powder. It is soluble in water and it is acid-stable. It is chemically designated as 7-[(D-2-amino-2-(4-hydroxyphenyl)acetyl)amino]-3-methyl-8-oxo-5-thia-1-azabicyclo [4.2.0]oct-2-ene-2-carboxylic acid monohydrate. It has the following structural formula:



Clinical Pharmacology—DURICEF (cefadroxil monohydrate) is rapidly absorbed after oral administration. Following single doses of 500 and 1000 mg., average peak serum concentrations were approximately 16 and 28 mcg./ml., respectively. Measurable levels were present 12 hours after administration. Over 90 percent of the drug is excreted unchanged in the urine within eight hours. Peak urine concentrations are approximately 1800 mcg./ml. during the period following a single 500 mg. oral dose. Increases in dosage generally produce a proportionate increase in DURICEF urinary concentration. The urine antibiotic concentration, following a 1 gm. dose, was maintained well above the MIC of susceptible urinary pathogens for 20 to 22 hours.

MICROBIOLOGY: *In vitro* tests demonstrate that the cephalosporins are bactericidal because of their inhibition of cell-wall synthesis. DURICEF is active against the following organisms *in vitro*:

Beta-hemolytic streptococci
Staphylococci, including coagulase-positive, coagulase-negative, and penicillinase-producing strains
Streptococcus (Diplococcus) pneumoniae
Escherichia coli
Proteus mirabilis
Klebsiella species

Note—Most strains of *Enterococci* (*Streptococcus faecalis* and *S. faecium*) are resistant to DURICEF. It is not active against most strains of *enterobacter species*, *P. morganii*, and *P. vulgaris*. It has no activity against *Pseudomonas* or *Herella* species.

Disc Susceptibility Tests—Quantitative methods that require measurement of zone diameters give the most precise estimates of antibiotic susceptibility. One recommended procedure (CFR Section 460.1) uses cephalosporin class disc for testing susceptibility; interpretations correlate zone diameters of the disc test with MIC values for DURICEF. With this procedure, a report from the laboratory of "resistant" indicates that the infecting organism is not likely to respond to therapy. A report of "intermediate susceptibility" suggests that the organism would be susceptible if the infection is confined to the urinary tract, as DURICEF produces high antibiotic levels in the urine.

INDICATIONS: DURICEF (cefadroxil monohydrate) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species
 Skin and skin structure infections caused by staphylococci and/or streptococci

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATION: DURICEF (cefadroxil monohydrate) is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE.)

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil monohydrate).

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil monohydrate) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 10 ml/min/1.73M²). (See Dosage and Administration.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side on Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

USAGE IN PREGNANCY: Although no teratogenic or anti-fertility effects were seen in reproductive studies in mice and rats receiving dosages greater than a normal human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

ADVERSE REACTIONS: Gastrointestinal—The most frequent side-effect has been nausea. It was infrequently severe enough to warrant cessation of therapy. Administration with food decreases nausea and does not decrease absorption. Diarrhea and dysuria have also occurred.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

DOSAGE AND ADMINISTRATION: DURICEF (cefadroxil monohydrate) is a stable and may be administered orally without regard to meals. Administration with food may be helpful in diminishing potential gastrointestinal complaints occasionally associated with oral cephalosporin therapy.

Adults—For urinary tract infections the usual adult dosage is one gm. (two 500 mg. capsules) two times per day. For skin and skin structure infections the usual dose is 500 mg. two times per day or 1 gm. once a day.

In patients with renal impairment, the dosage of cefadroxil should be adjusted according to creatinine clearance rates to prevent drug accumulation. The following schedule is suggested. In adults, the initial dose is 1 gm. of DURICEF (cefadroxil monohydrate) and the maintenance dose (based on the creatinine clearance rate [ml/min/1.73M²]) is 500 mg. at the time intervals listed below:

Creatinine Clearances	Dosage Interval
0-10 ml/min	36 hours
10-25 ml/min	24 hours
25-50 ml/min	12 hours

Patients with creatinine clearance rates over 50 ml/min may be treated as if they were patients having normal renal function.

Children—Dosage and safety have not yet been established in children.

HOW SUPPLIED: DURICEF® (cefadroxil monohydrate) capsules 500 mg. for oral administration in an opaque maroon cap and opaque white body No. 0 has gelatin capsule. On each half capsule printed in black is "MJ" and "500." Available in bottles of 24 capsules (NDC 0087-0784-41) and 100 capsules (NDC 0087-0784-42).

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Radiological

CASE OF THE MONTH

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LEE A. GOODMAN, MD

DAVID McNEELY, MD

Guest Editors: Glenn R. Edgecombe, MD
Kenneth Margolis, MD
Charles I. Weiner, MD

From the Departments of Family Practice, Medicine and Radiology at Franklin Square Hospital, Baltimore County, MD. A special thank you goes to James F. Todesco, MA, RBP, SBPA, RT, Medical Communications at Franklin Square Hospital.

Case History

A 54-year-old white male was admitted for evaluation of bloating and weight-loss. In the six months prior to his admission, the patient lost 35 pounds, which he attributed to his bloating and early satiety. After eating, he experienced minimal epigastric pain without nausea or vomiting.

Physical examination was normal. There was no succussion splash. Abdominal radiographs were normal. Upper GI radiographs (Figures 1 and 2) demonstrate a narrowing of the second portion of the duodenum which appeared well epithelialized. There was no evidence of peptic disease; there was retained material in the stomach. Endoscopy revealed an area of narrowing, but no intrinsic bowel disease.

What is the differential diagnosis? What is your diagnosis?

Answer on next page.



FIGURE 1

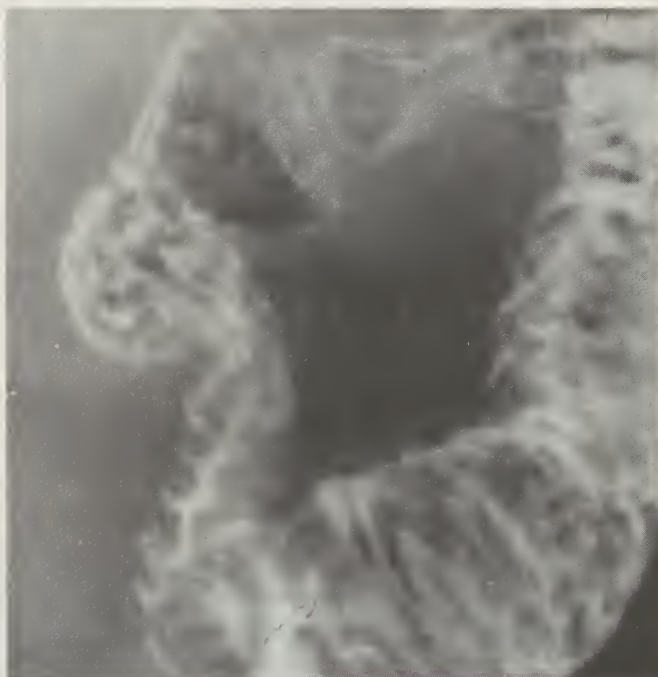


FIGURE 2



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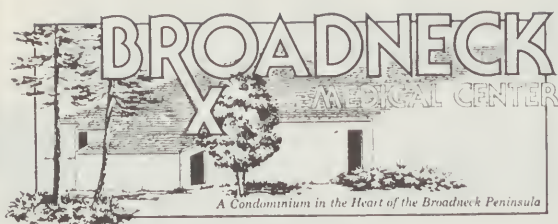
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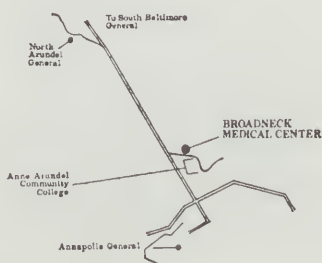
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Radiological Case of the Month

Case history on preceding page.

Diagnosis: Annular Pancreas

Discussion

At laparotomy, the impression of annular pancreas constricting the duodenum was confirmed. The lesion was bypassed and the patient had an excellent post-operative result.

Annular pancreas is a rare congenital anomaly apparently caused by a failure of fusion of the ventral and dorsal buds of the developing pancreas. The ventral bud develops independently and surrounds the second portion of the duodenum. A study of 20,000 autopsies at Johns Hopkins Hospital revealed only three cases of annular pancreas.¹

The degree of mechanical obstruction to the duodenum is variable, but, in the usual case, the duodenum is completely surrounded by a band of pancreatic tissue. Pancreatic tissue may sometimes infiltrate the muscularis propria of the duodenum. This is one of the few congenital anomalies of the gastrointestinal tract that often does not become apparent until adult life.² Diagnosis is made when significant symptoms are produced by a significant partial obstruction.

Annular pancreas first seen in the neonatal period is commonly associated with duodenal atresia and the radiographic findings are usually typical. Later in childhood, cases are detected because of a partial intermittent obstruction. Over 50% of cases are detected in the adult with a peak incidence in the fourth or fifth decades. It is twice as commonly found in the adult male than female.³ Concomitant peptic ulcer disease is reported in 30-40% of cases and pancreatitis in as many as 15-25%.⁴ The reason for the high incidence of pancreatitis is unknown, but may be related either to minor trauma or inadequate drainage of the ring of pancreatic tissue.⁵

The obstruction produced is often non-specific; however, there frequently will be a typical bandlike deformity of the second duodenum which is often somewhat eccentric. Differential diagnosis includes obstruction from duodenal ulcer alone, obstruction from pancreatitis, postoperative adhesions or duodenal carcinoma (usually has an "apple-core" appearance). Peritoneal or mucosal bands usually produce short constrictions. Extrinsic compression of the second portion of the duodenum has been reported in children by hyperplastic lymph nodes.

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Coming in the Journal:

The Future of Primary Health Care: Responsibility of Today's Practitioners by H. Jeffrey Ziegler, BS, MHS; Timothy Baker, MD, MPH, and Oscar C. Stine, MD, Dr. PH

Doctors in the News

Dr. Posner Named

Dr. David B. Posner has been appointed head of Mercy Hospital's Division of Gastroenterology, according to an announcement by Sister Mary Thomas, RSM, President of the Hospital.

A graduate of the California Institute of Technology with a bachelor of science degree in chemistry, Dr. Posner received his Medical Degree from the University of Maryland School of Medicine and served his internship at Harbor General Hospital in Torrance, CA. He was a resident at the University of Maryland Hospital, where he earned a fellowship in gastroenterology.

An Assistant Professor of Medicine at the University of Maryland School of Medicine, Dr. Posner is certified by the American Board of Internal Medicine. He became eligible for certification by the American Board of Internal Medicine in Gastroenterology in 1978. He holds membership in the American Medical Association, American College of Physicians, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy and



DR. POSNER

(Photo by Tadder, Baltimore.)

the American Association for the study of Liver Disease.

Locally, Dr. Posner belongs to the Baltimore City Medical Society and is a member of the Faculty. He and his family reside in Reisterstown.

Dr. Drucker Presents Stewart Memorial Lecture

William R. Drucker, MD, Professor and Chairman of the Department of Surgery at the University of Rochester, was the guest speaker at the St. Agnes Hospital Department of Surgery's eighth annual "Day of Surgery" Nov. 30th, and presented the **George A. Stewart Memorial Lecture** at St. Agnes in the Residence Building Auditorium on **Metabolic Basis for Therapy of Septic and Hemorrhagic Shock**.

Joining Dr. Drucker in an open forum panel discussion following the lecture were **Sheldon E. Greisman, MD**, Professor of Medicine and Physiology at the University of Maryland School of Medicine; **Andrew M. Munster, MD**, Associate Professor of Surgery at the Johns Hopkins Hospital School of Medicine and **Clayton G. Shatney, MD**, Chief of Surgery and Traumatology at the Maryland Institute for Emergency Medical Services of the University of Maryland.

In addition to his current position at the University of Rochester, Dr. Drucker has served as Professor of Surgery and Dean of the School of Medicine, as well as Chief of Staff at the University of Vir-

ginia Hospital, and Professor and Chairman of the Department of Surgery at the University of Toronto. At the Western Reserve University School of Medicine, Dr. Drucker was Instructor and Professor of Surgery.

Dr. Drucker received his Medical Degree from the Johns Hopkins Hospital, and completed his undergraduate work at Harvard College. □

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MEMBERS OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION enjoyed their annual crab feast on Sept. 26, 1979 at the Sparrow's Point Country Club in Dundalk, MD. In top photo, BCMA President Lawrence F. Misanik, MD looks up from his crab and into the waiting camera lens, while (below) are (from left to right) Drs. Martin E. Strobel, Margaret L. Sherrard and James E. Peterman. (Both pictures courtesy the BCMA.)

Black Physicians and the Faculty:

Two Fine Portraits Added to the Faculty's Collection

At its meeting on Sept. 29, 1979, the Faculty Council formally accepted portraits of Daniel Coit Gilman and Reverdy M. Hall, MD. These two fine oil paintings join the Faculty's very valuable collection of portraits of individuals who were prominent in the history of the Faculty.

Daniel Coit Gilman (1831-1908) was an educator, not a physician. He is generally remembered as the creator of the American type of university because of his efforts in laying the foundation for the present University of California, and for his roles as the first President of the Johns Hopkins University. It is easily overlooked or forgotten that Gilman, in establishing the Medical School at Johns Hopkins, set the model which most then-existing medical schools tried to follow, and after which later medical schools were patterned. Through Dr. Gilman, Dr. William Welch was made the first Professor of Pathology at the Hopkins Medical School, followed by Dr. William Osler as Professor of Medicine, Dr. Howard Kelly as Professor of Gynecology and William Halsted as Professor of Surgery. The Medical and Chirurgical Faculty might be a different organization today were it not for the influence of these great physicians.

Dr. Gilman was a close friend of the Faculty. The **Transactions** of the Faculty during the late 1800s and early 1900s are full of references to him as he made meeting rooms available to the Faculty, gave testimony before various Faculty committees, etc. Dr. Gilman was a speaker at the Faculty's centennial anniversary in 1899 at the Hotel Rennett. He was also involved in many of the behind-the-scenes activities to raise funds for the present Faculty Building and meeting hall.

The portrait of Dr. Gilman was painted in 1900 by the prominent Baltimore artist Paul Hullwig. It hung for many years in the home of Dr. Curtis Burnam, who passed it on to his son-in-law, Dr. Howard C. Smith; it came to the Faculty through Dr. Smith's daughter, Mrs. Sally Miller.

Reverdy M. Hall, MD, was born in Baltimore in 1846. His parents were freed blacks who owned and farmed land in Anne Arundel County. He was sent to Bridgewater, MA for his early education and received his MD degree from Howard University in Washington, DC in 1872. He returned to Baltimore and set up practice. He was attending physician at Provident Hospital in Baltimore and later became Director of the Hospital. He was also the attending physician at the Industrial Home for Colored Girls in Melvale, MD. He was admitted to the Faculty in 1884 on the recommendation of Dr. Thomas Opie, becoming the second black physician to be so admitted. Dr. Hall died in 1917.

The portrait of Dr. Hall comes to the Faculty through the generosity of his granddaughter, Miss Edna Brown. It is the first portrait of a black physician to grace the halls of the Faculty Building.

The donation of the portrait of Reverdy M. Hall, MD to the Faculty raised a question in my mind about the history of the Faculty and black physicians.

The first source for answers to any question regarding the Faculty, at least before the year 1900, is always Dr. Eugene Cordell's **Medical Annals of Maryland, 1799-1899**. In the index of that book, under the term "Colored Physicians," there are two references. The first is to the chronology, which for the year 1882 has the following paragraph:

"The first colored physician was admitted this year, Whitfield Winsey, MD, of Baltimore, a graduate of Harvard University, having that honor. Dr. Winsey had been previously rejected by a local society in East Baltimore, where he resided, and he must have felt fully compensated for his previous disappointment in the unanimous recommendation of the Board of Examiners and the unanimous election of the Faculty. Two other physicians of color have since been added to the membership. In a society such as this, representing the entire State and designed for purely scientific and ethical purposes, there should be no requirements other than those of character and attainment."

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These words are especially significant because they referred to a time less than 20 years after the end of the American Civil War and the abolition of slavery, and because these events occurred in a society consisting of a large number of members who had served as soldiers in the Confederate Army. Dr. Cordell, himself, had been a Confederate soldier.

Cordell's index also refers to the biographical section about Whitfield Winsey, MD. No other information on the topic is given in Cordell, nor does the book identify the additional two black physicians admitted during this period.

During my seven years of acquaintance with the Faculty, I had come across the above passage in Cordell several times, making me curious as to who the additional physicians were. I had also long suspected that there was more to the story. Additional light on the subject came in 1978 from Ms. Una Corbett, who was doing research on black physicians in Maryland and used the Faculty Library. From Ms. Corbett came the name of Reverdy M. Hall, MD as the second black physician admitted to the Faculty. Having the name, I could easily check Cordell to determine that Dr. Hall was indeed a member of the Faculty, but there is nothing there to indicate positively that he was the second black physician admitted. The third physician mentioned by Cordell remained nameless.

The last piece of this puzzle fell into place when, a couple of months ago, I was reading through the **Transactions** of the Faculty, searching for information

about the Anne Arundel County Medical Society, and came across the Trimble lecture for the year 1927, given by Randolph Winslow, MD. Entitled **Recollections of 50 Years of the Medical and Chirurgical Faculty**, Dr. Winslow's talk contained several interesting tidbits of Faculty history, and there was one paragraph specifically about Negro physicians:

"In 10 years the membership remained almost stationary. Three physicians of negro extraction were elected members, which caused such dissatisfaction that some of our valued associates handed in their resignations. Dr. Whitfield Winsey was a very blond man, whom no one would suspect of having negro blood, but he never claimed to be otherwise. He was a graduate of Harvard Medical School and was a very reputable man. Dr. Reverdy M. Hall would also have passed for a white man, while Dr. William H. Thompson was an unmistakable negro. The arrangement was not satisfactory, and no others of the colored race have been elected since."

Dr. Winslow's lecture, while providing the name of the third black physician admitted to the Faculty in the 1880s, raised more questions than it answered. I was left curious, wondering about the debate that must have accompanied the admission of these black physicians to the Faculty, and also what the role was of these black physicians in the activities of the Faculty. I was also curious as to whether no other black physicians applied for membership in the Faculty after this time or there were applications that were turned down. Answers to all these questions are slow in coming; however, I have uncovered several items by studying the Faculty's **Transactions** and other records. Dr. Whitfield Winsey was presented for membership by the unanimous recommendation of the Board of Examiners for the Western Shore on Apr. 11, 1882, and he was admitted to membership by unanimous vote of the Faculty on the next day. Dr. Winsey immediately became very active in Faculty affairs, serving on many committees and regularly presenting papers at the Annual Meetings of the Faculty.

Dr. Reverdy M. Hall was proposed for membership in the Faculty by Dr. Thomas Opie in 1884 and was elected that same year. Dr. Hall served on the Faculty Council as a delegate from the Clinical Society, a smaller medical society in Baltimore.

Dr. William H. Thompson was proposed for membership by the Western Shore Examining Board in 1887 and was unanimously elected.

The actual discussions about the admissions of these three black physicians to the Faculty and the resignations by prominent members because of their admission are matters that require further study, but several events briefly mentioned in the **Transactions** may be clues.

In 1881, it was pointed out that the Faculty's bylaws included no provision for resignations; this matter was studied and changed. At the 1882 Annual Meeting, several physicians resigned from the Faculty, but this occurred before Dr. Whitfield Winsey's name was proposed for membership. In 1884, shortly after Dr. Reverdy M. Hall's admission to the Faculty, J. Edwin Michael, MD announced his intention to propose a motion at the next Annual Meeting to change the Faculty's constitution and bylaws so that the words "gentleman"

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and "gentlemen" would be replaced by "person" and "persons." This resolution was presented and adopted at the 1885 meeting. I am curious as to whether Dr. Michael proposed this resolution because the Faculty was now admitting black physicians or whether it was to open the way for the admission in 1886 of Amanda Taylor Norris, MD, to the Faculty. I believe she was the first female physician admitted by the Faculty.

My research seems to confirm Cordell's statement in his *Annals* that these three black physicians were the only blacks admitted to the Faculty prior to 1900; however, there seems to be some discrepancy with Dr. Winslow's statement in his 1927 Trimble address that "No others of the colored race have been admitted since."

John Ruhräh, MD spent much of his later life editing and compiling a second volume to Cordell's *Annals* that was to cover the history of the Faculty between the years 1900-25. As yet, this volume has not been published, except for some segments that have appeared recently in the *Journal*. As part of his research, Ruhräh compiled biographical information about all Faculty members who practiced in Maryland during this period. An initial examination of the more than 2,000 biographies in Ruhräh's work shows that approximately 40 of the biographies are of black physicians. Since Ruhräh was doing his work during the early 1930s, and Randolph Winslow's speech was in 1927, it seems unlikely that all these black physicians would have been admitted to the Faculty during the short time between those years. One suspects that Ruhräh attempted to include all physicians, not just Faculty members. This interpretation is further strengthened by a comment made by Dr. Winslow at a 1932 meeting of the Faculty Council. The body was discussing a request for admission received from a black physician in Silver Spring when Dr. Winslow stated that it was not the policy of the Faculty to admit colored physicians. The membership application was sent to the Montgomery County Medical Society for action.

By the late 1930s, the question of black membership in the Faculty had reached significant proportions. The American Medical Association readily admitted blacks, but maintained their rule that admission to the national association depended on admission to a state society, which, in turn, depended upon admission to county or local societies. There were, in fact, black members of the AMA from as far back as 1900.

In 1939, the AMA as a result of negotiations with the National Medical Association, reaffirmed its willingness to admit black physicians and also agreed to remove the discriminatory term "colored" after the names of black physicians listed in the AMA *Directory*.

That same year, George McDonald, MD, President of the Maryland Medical, Dental and Pharmaceutical Association's Medical Section—which represented black physicians in Maryland—addressed a letter to the Faculty Council. This letter first of all addressed generally the health problems of the Negro citizens of Baltimore and the state, who comprised one-seventh of the population. The letter went on to point out that the Negro physician, after graduating from an approved medical school, serving an approved internship and, in many instances, an approved residency, entered into

private practice and then found the avenues to further professional advancement closed to him. In Maryland the doors to postgraduate instruction, clinics, hospitals and—to quote Dr. McDonald, "worst of all"—the official medical library of the state were not open to him. Black physicians were not even allowed to listen in on the discussion of current medical problems by those people who had the advantage of using all the medical facilities of the city and state.

The letter further commented on the AMA's reaffirmation that there was no official barrier to Negro physicians in that organization, provided they were accepted into membership in their respective local societies. It was further pointed out that in many northern states there was no problem, and that several southern states, especially Texas, were seriously working on the dilemma. The letter concluded by asking the Council to consider the admission of fully qualified Negro physicians to scientific membership in the society or an arrangement of affiliation between the two societies that would give fully qualified Negro physicians membership in the AMA, and also to appoint a committee from the Faculty to meet with a similar committee from the black society to work out means to solve the problems.

As a result of Dr. McDonald's letter, a committee was formed under the chairmanship of George Finney, MD. In 1940, this committee submitted two recommendations to the House of Delegates: first, to allow members in good standing with the "Negro State Medical Society" to use the Faculty Library and, secondly, to allow them to attend scientific sessions in Osler Hall. The House of Delegates of the Faculty adopted these two provisions on Apr. 23, 1940. Shortly thereafter, the Baltimore City Medical Society passed a resolution extending to the members of the Monumental Medical Society (the Baltimore City society for black physicians) "The privilege of attending any medical or scientific session of the Baltimore City Medical Society which may be held in Osler Hall;" however, the resolution went on to state that "This motion is not to be construed as inferring any other privileges of membership either active or associate than those extended by the House of Delegates of the Medical and Chirurgical Faculty."

As a result of this action, about 40 or 50 black physicians were sent copies of the Faculty's *Bulletin* and given Library privileges. Most of these physicians were from Baltimore City, though a few came from the counties. A fee of \$3 per year was charged to these physicians to cover the cost of library privileges. A letter went out to the black physicians in the counties reminding them that they were entitled to request and borrow Library materials through the mail, with the Library paying the cost. In looking through the records and the names of the black physicians who year after year paid their \$3, I found that there was active use of the Faculty Library by this group.

The coming of World War II seems to have intervened in any further progress on the problem, but following the coming of peace, the issue was promptly revived. It is interesting that although only seven to eight years had passed, much effort had to be devoted to "reinventing the wheel," that is, to redetermining that which had already been determined.

This time, the impetus came from Anne Arundel County. In 1947, Dr. Theodore H. Johnson, a black Annapolis physician, requested admission to the Anne Arundel County Medical Society. Dr. Johnson had applied for hospital privileges on the staff of the Annapolis Emergency Hospital (now the Anne Arundel General Hospital), but these privileges were refused on the grounds that Dr. Johnson was not a member of the state medical society. In response, Dr. Johnson applied for membership in the Faculty.

The problem had deeper roots and presented the Faculty with an almost impossible dilemma. Dr. Johnson was running a small obstetrics hospital in Annapolis for black patients. The Maryland State Health Department recognized that Dr. Johnson's hospital was very fine, in spite of having only limited resources. Although it could comply with applicable Health Department regulations, the hospital could not be licensed because it was too small. Accordingly, the Health Department ruled that the hospital had to be closed, but it refrained from taking this action because the Emergency Hospital in Annapolis would not yet admit colored obstetrics patients. At the time, Dr. Johnson's maternity hospital was the only hospital in Anne Arundel County accepting black obstetrics patients, and so, although the Health Department refused to license the hospital, they could not close it.

An interesting side note is that up until 1952 black physicians were excluded from the medical staff of the Annapolis Emergency Hospital, even though one of the founders of the hospital in 1902 had been Dr. William Bishop, who had been born as a slave in Annapolis in 1849.

The Faculty's response to Dr. Johnson's application was to refer him to the Anne Arundel Medical Society. At the same time, the Secretary of the county society was informed that it was up to each component society to set the qualifications of prospective members. In effect, the officers of the Faculty were stating that they would accept black members if they were first admitted to a component society. Dr. Johnson's application for membership was evidently rejected, as were subsequent applications by three additional black physicians in Anne Arundel County.

Not only Anne Arundel County had to face the issue; in 1947 Charles County and Dorchester County also received applications from black physicians for membership. In each case a black physician, after applying for admission privileges at a local hospital, had been told that he first had to be a member of the county and state medical societies. As a result of these applications, the Faculty's secretary wrote to the AMA asking for a statement. His letter illustrates how the problem was seen from both sides:

"It seems fitting that the Negro not be denied educational advantages and postgraduate advancement, but in the South it is difficult to find a way to arrange this without causing a certain social embarrassment, particularly inasmuch as in many counties the meetings are held in the physicians' homes and many of the other meetings are dinner meetings."

Again a committee was formed to study the issue of membership for colored physicians in the Faculty and component medical societies. This time the committee



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was under the chairmanship of Dr. John M. T. Finney, Jr. The first report of this committee was presented to the Faculty's Council and House of Delegates on Oct. 14, 1948. The committee had five recommendations: 1) All purely professional privileges and membership in the Medical and Chirurgical Faculty of Maryland and its

constituent societies should be opened to acceptable Negro doctors by the prescribed method of election to that society. 2) These privileges and membership should not extend to purely social functions. 3) No funds of the Faculty or its component societies should be expended for any social function; all expenditures of society funds should be limited to strictly professional matters. 4) The Faculty and each component society should appoint a standing committee known as the Entertainment Committee, whose duty would be to arrange for social functions in connection with any meeting and to arrange for payment thereof outside the funds of the society. 5) The question of membership on any hospital staff is entirely a matter for decision by proper authorities of that individual hospital.

From the correspondence that was generated around this committee and its activities, it seems obvious that there was little doubt that the professional requests from the black physicians were justified. It appears that the major concern was the social embarrassment that would result from the possible participation of blacks in the Faculty's social functions. The second and third recommendations were felt necessary to assure that there would be no complaint from the black physicians after they became members that their dues were being used for functions which they could not attend. A curious sidelight of Dr. Finney's committee's reports is the fact that the committee held its meetings at the Maryland Club, where no black would have been welcome except as a waiter or doorman.

The report to the House of Delegates elicited considerable discussion. It is known that Dr. Huntington Williams, Dr. Shipley and Dr. Bird all argued in favor of the motion to accept it, presenting examples of past professional cooperation with colored physicians that did not cause any social embarrassment. Dr. Bird urged that the state association was obliged to help colored physicians to the limit of its ability. Dr. Finney's committee's report was accepted by the House of Delegates with appreciation. A new committee was appointed to further study the problem, and the delegates were asked to discuss the problem with their component societies so that this new committee could evaluate the opinions of the component societies and report back to the House of Delegates.

Early in 1949, a letter was sent to the president and secretary of each component society, along with a copy of the report of the committee. Each component society was asked to indicate the consensus of their membership regarding two questions: 1) Should colored physicians be granted membership? and 2) If such a privilege is granted, should professional and social functions be disassociated? Dr. Finney, chairman of the previous committee, was also chairman of the new special committee to study the problem, and it was his task to compile and evaluate the results of the questionnaire. When the results were tabulated, 10 county societies voted unanimously to grant black physicians membership in the Faculty and component societies; however, most indicated that the social functions should be kept separate. Three component societies had divided votes, two with the majority opposed to admitting black physicians, and one with the majority in favor of black physicians. Seven county societies were unanimously opposed to granting black physicians membership; two

counties tabled the matter with no expression of feeling and one county did not reply. It is interesting that the special committee was able to tabulate the results in a way that indicated a tie with 11 component societies favorable and 11 unfavorable, with one not replying.

As I examined the record, it appeared quite probable that, had the latter county replied, its vote would have been unfavorable, but then the committee could still have managed to work a tie out of the results by counting Allegany and Garrett Counties in favor, as two separate votes rather than one; these two counties had a joint medical society at the time.

About this time, somebody must have looked into the **Transactions** of the Faculty, for Dr. Finney introduced as new evidence the fact that the concept of admitting black physicians to the medical society was not a new question or a revolutionary idea. Dr. Finney seemed almost delighted to report that in the 1880s the Faculty admitted at least three colored members, one of whom took a quite active part in its meetings and contributed several papers. To quote the conclusion of Dr. Finney's report:

"How many other members there may have been or over what period of years or any reasons for discontinuance of such memberships cannot be ascertained. The fact remains, there have been colored members of the Faculty in the past."

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On Apr. 19, 1949, Dr. Finney presented the special committee's report to the House of Delegates; this report states that "Negro physicians and surgeons, who professionally meet the requirements for membership in the component City and County Societies of the Faculty should be accorded such membership by due election to same." The report goes on, however, "It should remain, as always, the prerogative of each individual component society to determine their own standards for eligibility for election, however. The committee simply urges for their consideration the justice of such professional recognition for all of our fellow practitioners."

The report goes on to point out that membership in the AMA depends on membership in one's state society, which, in turn, is dependent on election to a component city or county society. Again quoting from the report: "It would seem hardly fair to ask or expect one whole group to conform to principles of ethics and practice laid down by an organization and its component state parts in which they have neither membership nor representation." The committee's report then goes on to show that the admission of black physicians to the Faculty and its component parts is of vital interest to the patient, the profession, the community and the country as a whole. The committee stated in conclusion that it was not unmindful of the problems which would attend such a course of action; however, rather than following the line of carefully distinguishing social and professional activities, the committee merely stated that it might be necessary to make certain departures from, and rearrangements of, accustomed methods of holding and handling meetings, at both the state and local levels. The committee felt that such obstacles were not insurmountable at either city or county level, as well as at the state level of the Faculty.

The committee's report was accepted and the matter was settled, at least on the state level. In August, 1949, black physicians in Baltimore City were notified that they were eligible for membership in the city society and that by joining it would no longer be required to pay \$3 a year to use the Faculty Library. After this time letters addressed to the Faculty from component societies regarding black physicians were answered with a statement that the qualifications for the admission for a black physician to the Faculty were to be the same as for white physicians.

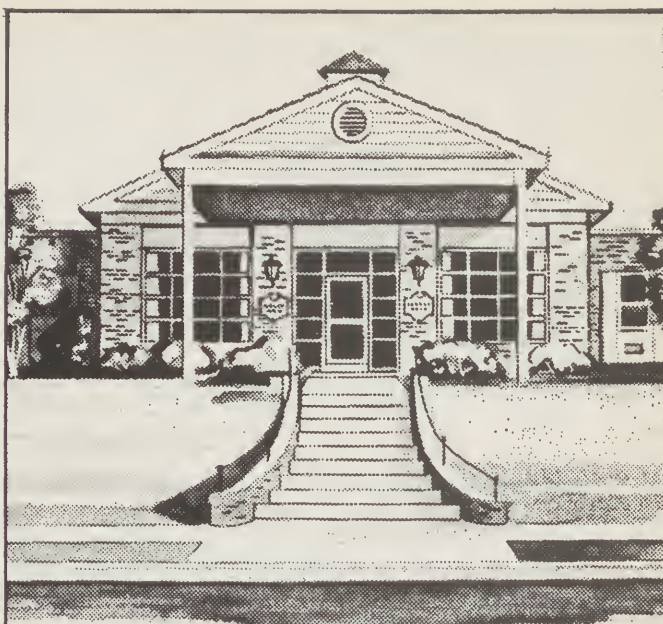
It seems that shortly thereafter, perhaps around the year 1950, the members of the black Maryland Medical Society joined the Faculty in a body through the Baltimore City Medical Society. By 1953, there were 45 black physicians in the Medical Society—13 from the counties and 32 in the city. Happily, Dr. Theodore Johnson in Anne Arundel County, whose request for membership in the Faculty in 1947 had initiated all this activity, was one of the first of the black physicians to be admitted to the Anne Arundel County Medical Society and to receive privileges to practice at the Annapolis Emergency Hospital.

The social problems anticipated by the committee were quick to surface. While the Faculty members were willing to include black physicians at their scientific meetings, and even at social functions, the hotels and restaurants where the Faculty and its component societies frequently held their meetings were not. For a while, the Faculty tried sending invitations for social functions to black physicians only when it was known that they would be admitted. This became very difficult, especially because the Baltimore City Medical Society, which had the largest black membership, followed the guidelines very strictly and did not indicate on its membership records in any way the race of the member. Thus, in 1953, it was decided to hold the meal functions for the Faculty's annual meetings at the Faculty building. This practice was followed until about 1958, when some of the Baltimore City hotels agreed to let black physicians join with other physicians at Faculty functions, as long as these were private functions. There continued to be a problem, however, for Faculty meetings held away from Baltimore City and out-of-state.

In 1962, the House of Delegates of the Faculty passed a resolution urging the rapid integration of medical schools, internships, residencies and hospital staff privileges. The resolution pointed out the many assaults upon the medical profession then being mustered and emphasized the importance of presenting a united front. The resolution presented the total integration of the medical profession as essential for the health and well-being of the people of the country and the strength of the medical profession.

In 1963 and 1964, the Baltimore County Medical Society presented resolutions that would have prevented the Faculty from holding a meeting at any facility where blacks would not be allowed to participate equally. The resolutions were tabled both times, and it appears that the civil rights laws forbidding segregation in restaurants and hotels overtook the Faculty and solved the problem first.

This is obviously not the total story of black physicians and medicine in Maryland. I have said nothing



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about the several black medical schools that existed in Maryland, especially around the turn of the Century, and nothing about the many hospitals for blacks that existed in Baltimore City. There is evidence that black physicians were scattered throughout the state of Maryland, even though the majority were in Baltimore City, and most of the activities for black physicians centered in Baltimore City. During the 1930s, there were a large number of different medical societies for blacks, all of them somehow interconnected; the minutes and proceedings from those societies would make a fascinating study in themselves.

Most of the research for this paper was based on minutes and summaries of meetings. Because of the nature of these documents, they usually only hint at what was going on behind the scenes. While some may be quick to harshly judge the Faculty in this matter, I think it should be pointed out that at no time and in no place did the Faculty take an official position refusing to admit black physicians. Furthermore, there is evidence that there were many prominent physicians, most of them officers in the Faculty, who were working for the rights of black physicians and trying hard to have them admitted to the component societies and the Faculty itself in a manner that would leave the Faculty stronger because of these activities. There were two reasons for admitting blacks to the state medical society: first and foremost, of course, was the justice of their request, and second was the need for organized medicine to represent all physicians. When black physicians were admitted to the Faculty, it was because they were accepted and endorsed by their county societies. Had the admission of black physicians to the component societies been

dictated by the Faculty, the resignations and protests of Faculty members that would have resulted would have left the Faculty weaker and more divided, and even less representative of the medical profession.

In searching out the facts behind this history, I saw that the leaders of the Faculty were in the midst of a storm of impossible dilemmas. Charting the Faculty's course through this storm was a delicate task, calling for the greatest diplomacy, tact and firmness. The success of Dr. George Finney and Dr. John M. T. Finney, Jr. in accomplishing this most difficult task is due much more recognition that has previously been granted.

JOSEPH E. JENSEN
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Selected Medical Literature Searches

The following are among the computerized medical literature searches provided to Med-Chi members during the month of September, 1979:

1. Confidentiality with computerized patient records	27	Citations
2. Sexual adjustment and problems in paraplegic males	15	"
3. Cyproheptadine therapy for various headaches	12	"
4. Side-effects of lithium carbonate therapy	25	"
5. Cortisone-producing osteonecrosis in the hip	8	"
6. Hypothermia treatment of cancer	20	"
7. Management of pregnant women with genital herpes	23	"
8. High carbohydrate diets for diabetics	20	"
9. Disseminated intravascular coagulation in pregnancy	26	"
10. Natural childbirth	38	"

If you would like a copy of one of these searches or would like to have a search run on any biomedical topic, call or write the Library.

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New Book Titles

Arthritis

- WE 344
.A 7866
1979
- Arthritis and Allied Conditions: a Textbook of Rheumatology.** Edited by Daniel J. McCarty. 9th ed. Philadelphia, PA, Lea and Febiger, 1979.

Autopsy

- QZ 35
.L 948c
1979
- Ludwig, Jurgen, 1931—**Current Methods of Autopsy Practice.** 2d ed. Philadelphia, PA, Saunders, 1979.

Brain Injuries

- WL 354
.N 494
1978
- Neural Trauma.** Edited by A. John Popp. New York, Raven Press, 1979.

Coronary Disease

- WG 300.3
.F 612e
1979
- Fletcher, Gerald F., 1935—**Exercise and Coronary Heart Disease: Role in Prevention, Diagnosis, Treatment.** 2d ed. Springfield, IL, Thomas, 1979.

Diagnosis, Differential

- WB 141.5
.H 341d
1979
- Harvey, Abner McGehee, 1911—**Differential Diagnosis: the Interpretation of Clinical Evidence.** 3d ed. Philadelphia, PA, Saunders, 1979.

Drug Interactions

- QV 38.3
.H 251d
1979
- Hansten, Philip D. **Drug Interactions: Clinical Significance of Drug-Drug Interactions and Drug Effects on Clinical Laboratory Results.** 4th ed. Philadelphia, PA, Lea and Febiger, 1979.

Emergency Health Services

- WO 700
.G 475s
1979
- Gill, William, 1937—**Shock Trauma Manual.** Baltimore, Williams and Wilkins, 1979.

Hematologic Diseases

- WS 300
.S 644b
1978
- Smith, Carl Henry, 1895—**Smith's Blood Diseases of Infancy and Childhood.** 4th ed. St. Louis, Mosby, 1978.

Home Care Services

- WY 115
.B 198f
1979
- Balzano, Michael P. **Federalizing Meals-On-Wheels; Private Sector Loss or Gain?** Washington, DC, American Enterprise Institute for Public Policy Research, 1979.

Homosexuality

- WM 615
.M 423h
1979
- Masters, William Howell, 1915—**Homosexuality in Perspective.** Boston, Little Brown, 1979.

Immunologic Diseases

- WD 300
.I 33
1978
- Immunological Diseases.** Edited by Max Samter. 3d ed. Boston, Little Brown, 1978.

Kidney Diseases

- WJ 300.3
.P 218c
1978
- Papper, Solomon, 1922—**Clinical Nephrology.** 2d ed. Boston, Little Brown, 1978.

Myocardium

- WG 280
.B 796m
1978
- Brachfeld, Norman **Myocardial Metabolism and Bioenergetics.** Kalamazoo, MI, Upjohn Co., 1978.

Neck Neoplasms

- WE 705
.B 334t
1979
- Batsakis, John G. **Tumors of the Head and Neck; Clinical and Pathological Considerations.** 2d ed. Baltimore, Williams and Wilkins, 1979.

Neoplasms

- QZ 266
.C 217
1979
- The Cancer Patient: Social and Medical Aspects of Care.** Edited by Barrie R. Cassileth. Philadelphia, PA, Lea and Febiger, 1979.

Nutrition

- QU 145.3
.G 984i
1979
- Guthrie, Helen Andrews **Introductory Nutrition.** 4th ed. St. Louis, Mosby, 1979.

Pediatrics

- WS 100.3
.N 424
1979
- Nelson Textbook of Pediatrics.** Edited by Victor C. Vaughan, III, R. James McKay, Jr., and Richard E. Behrman. 11th ed. Philadelphia, PA, Saunders, 1979.

Physiology

- QT 104.3
.G 992p
1979
- Guyton, Arthur Clifton, 1919—**Physiology of the Human Body.** 5th ed. Philadelphia, PA, Saunders, 1979.

Schools, Medical

- W 19
.B 879g
1979
- Brown, Sanford Jay, 1946—**Getting into Medical School: the Premedical Student's Guidebook.** 4th ed. Woodbury, NY, Barron's Educational Series, 1979.

Sex Behavior

- HQ 21
.H 819
1979
- Human Sexuality: a Health Practitioner's Text.** Edited by Richard Green. 2d ed. Baltimore, Williams and Wilkins, 1979.

Skin Diseases

- WR 100.3
.D 435
1979
- Dermatology in General Medicine: Textbook and Atlas.** Edited by Thomas B. Fitzpatrick [et al.]. 2d ed. New York, McGraw-Hill, 1979.

Sport Medicine

- QT 260
.A 512n
1977
- American Medical Association **19th Conference on the Medical Aspects of Sports.** Chicago, 1978.

Coming in the Journal:

Fetal Alcohol Syndrome by James S. Reiff, DO

Medical Education in Maryland: Cottage Industry to University, by Douglas G. Carroll, Jr., MD (1915-77)
and

Med-Chi in Annapolis: A Different View of How Maryland Physicians Help the State—For Free! by Elza Davis

Wrestling Problems: Articles Available Through the Med-Chi Library

Food and Water Restriction in the Wrestler, by Hursh, L.M., JAMA, 241(9):915-6, March 2, 1979.

Massive Pulmonary Embolism in a High School Wrestler, by Croyle, P.H., [et al.] JAMA, 241(8):827-8, Feb. 23, 1979.

The Physician and Optimum Body Weight for Junior High and High School Wrestlers, by Tower, J., Alaska Med. 20(4):60-2, July, 1978.

The Effects of a Collegiate Wrestling Season on Body Composition, Cardiovascular Fitness and Muscular Strength and

Endurance, by Kelly, J.M. [et al.] Med. Sci. Sports 10(2):119-24, Summer, 1978.

Hemodynamic Response to Submaximal Exercise after Dehydration and Rehydration in High School Wrestlers, by Allen, T.E. [et al.] Med. Sci. Sports, 9(3):159-63, Fall, 1977.

Weight-Loss in Wrestlers, by Buskirk, E.R., Am. J. Dis. Child 132(4):355-6, April, 1978.

Physiological Effects of Wrestling in Adolescents and Teenagers, by Taylor, A.W., J. Sports Med., 3(2):76-84, March-April, 1975.

Body Composition and VO₂max of Exceptional Weight-Trained Athletes, by Fahey, T.D., J. Appl. Physiol., 39(4):559-61, October, 1975.

Problem of Obesity in Japan, by Fujiwara, M., Bibl. Nutr. Dieta. (26):91-4, 1978.

The Rational Wrestler—A Pilot Study, by Horton, A.M., Percept. Mot. Skills 46(3 PT 1):882, June, 1978.

Report of Injuries Sustained During the US Olympic Wrestling Trials, by Estwanik, J.J. [et al.] Am. J. Sports Med. 6(6):335-40, November-December, 1978. □

Schoolboy Wrestler Suffers From Too Rapid Weight-Loss

Sports medicine experts have long been aware of potential health hazards to the schoolboy boxer or wrestler who must "make the weight" for a match by losing pounds rapidly.

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The athlete may suffer fever, nausea and weakness, and most likely will not perform at maximum capability. Usually, the physical damage is not permanent and body strength is restored with the regain-

ing of the pounds, but sometimes there are more serious, even life-threatening, hazards.

Philip H. Croyle, MD of St. Joseph Hospital, Denver, and colleagues reported in a recent issue of the **Journal of the American Medical Association (JAMA)** on a 16-year-old high school wrestler who suffered a massive blood clot in the lung as a result of excessive rapid weight-loss. Bypass chest surgery saved his life.

The athlete, who weighed 109 pounds, underwent rapid dehydration twice in one week, losing a total of 13 pounds, or 12% of his entire body weight. This brought on a condition in which a minor bruise suffered during the wrestling bout triggered a sizable blood clot. The clot blocked a lung. Post-operative recovery was smooth and the wrestler was well 18 months later, Dr. Croyle says.

The patient's youth and good physical condition sustained him for some time, but his condition finally deteriorated to such a precarious state that surgery was necessary.

Dr. Croyle concludes: "Athletes must avoid rapid weight loss before competition."

To make matters even worse, he was defeated in his match by an opponent he had handily beaten before. In weakened condition, his strength and skill were drastically reduced. □



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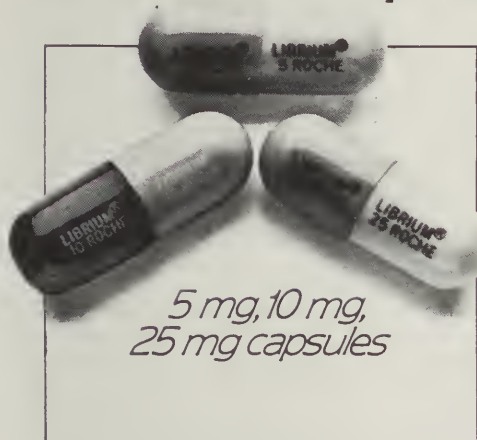
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

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